Evidence of Coverage

Effective January 1, 2025 – December 31, 2025

PERS *Gold*

Basic Plan

Preferred Provider Organization (PPO)

A Self-Funded Health Plan Administered by the
CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

Important Information

We have included a Summary of Benefits for the Basic Plan with a comprehensive description following. It will be to your advantage to familiarize yourself with this booklet before you need services.

Take time to review this booklet. The information contained will be useful throughout the year.

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

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

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect, and while the Benefits you are claiming are actually covered by this Plan. Benefits of this Plan are subject to change and an Addendum or a new booklet will be issued for viewing and/or distributed to each Member affected by the change. The latest updated Addendum and/or Booklet can be obtained through the website at includedhealth.com/calpers, or you can call 855-633-4436.

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 Blue Shield of California and Optum Rx® to administer the program.

NOTICE

This Benefit Booklet describes the terms and conditions of coverage of your health plan.

Please read this Benefit Booklet carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

If you have questions about the Benefits of your plan, or if you would like additional information, please contact Included Health at the address or telephone number listed on the back cover of this booklet.

Important Information

PLEASE NOTE

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor or clinic, or call Included Health at the telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

This Benefit Booklet constitutes only a summary of the PERS Gold Basic PPO Health Plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. However, the statement of Benefits, exclusions and limitations in this Benefit Booklet is complete and is incorporated by reference into the contract.

Notice about this Administrative Services Only plan: CalPERS is the Health Plan Purchaser. Blue Shield of California has been appointed the Third-Party Administrator. Ultimately, Blue Shield of California is responsible for processing and managing claims, utilization management and prior authorization determinations.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Benefit and Administrative Changes

Member Calendar Year
Medical Out-of-Pocket Maximum
The out-of-pocket maximum for medical expenses will be $7,200 per individual and $14,400 per Family. Your maximum Calendar Year Coinsurance Responsibility will be $3,000 per individual and $6,000 per Family.

Included Health
CalPERS Members and their eligible Dependents enrolled in the PERS Gold Basic PPO plan have access to Included Health, a healthcare navigation service available online, over the phone, or from their mobile app.

Doula Services
Your plan now includes coverage for doula services, including health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Support is provided before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doula services can be provided virtually or in person with locations in any setting including, but not limited to homes, office visits, Hospitals, or alternative birth centers.

Travel Benefit
Your plan now includes updated coverage for travel and lodging for eligible Medically Necessary services including, but not limited to abortion services, gender affirming care, complex surgeries, and cancer care that cannot be accessed within 50 miles from your residence, up to $5,000 per occurrence. This includes transportation, lodging, and meals for the Member and a companion (both parents/guardians when patient is under 18).

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well as the provider transparency requirements that are described below.

The CAA provisions within this plan apply unless state law or any other provisions within this plan are more advantageous to you.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Non-Preferred Providers;
- Covered Services provided by a Non-Preferred Provider at a Preferred Provider facility; and
- Non-Preferred Providers air ambulance services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Medical Conditions are covered under your plan:

- Without the need for prior authorization;
- Whether the provider is a Preferred Provider or Non-Preferred Provider;

If the Emergency Medical Conditions you receive are provided by a Non-Preferred Provider, Covered Services will be processed at the Preferred Provider Benefit level.

Note that if you receive Emergency Services from a Non-Preferred Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by a Preferred Provider. However, Non-Preferred Provider Cost Shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Non-Preferred Provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the Non-Preferred Provider determines: (i) that you are able to travel to a Preferred Provider facility by non-emergency transport; (ii) the Non-Preferred Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Non-Preferred Provider after you have received noticed that you are stabilized, you will be responsible for the Non-Preferred Provider Cost Shares, and the Non-Preferred Provider will also be able to charge you any difference between the maximum Allowable Amount and the Non-Preferred Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by a Non-Preferred Provider result from unforeseen and urgent medical needs arising at the time of service.

Non-Preferred Services Provided at a Preferred Provider Facility

When you receive Covered Services from a Non-Preferred Provider at a Preferred Provider facility, your claims will be paid at the Non-Preferred Provider Benefit level if the Non-Preferred Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network Cost Shares for those services and the Non-Preferred Provider can also charge you any difference between the maximum Allowable Amount and the Non-Preferred Provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the

following services: (A) emergency care; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Blue Shield of California will not apply this notice and consent process to you if we do not have a Preferred Provider in your area who can perform the services you require.

Non-Preferred Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or

2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by a Non-Preferred Provider at a Preferred Provider facility will be calculated using the median plan a Preferred Provider contract rate that we pay Preferred Providers for the geographic area where the Covered Service is provided. Any out-of-pocket Cost Shares you pay to a Non-Preferred Provider for either Emergency Services or for Covered Services provided by a Non-Preferred Provider at a Preferred Provider facility will be applied to your Preferred Provider Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from a Non-Preferred Provider, Covered Services from a Non-Preferred Provider at a Preferred Provider facility, or Non-Preferred air ambulance services, and those services are covered by the No Surprises Act, you have the right to appeal that claim. If your Appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Medical Claims Review and Appeals Process" section of this Benefit Booklet.

Provider Directories

Blue Shield of California is required to confirm the list of Preferred Providers in its provider directory every 90 days. If you can show that you received inaccurate information from Blue Shield of California that a provider was in-network on a particular claim, then you will only be liable for Preferred Provider Cost Shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Preferred Provider Cost Shares will be calculated based upon the maximum Allowable Amount.

Transparency Requirements

Blue Shield of California provides the following information on its website (www.blueshieldca.com):

- Protections with respect to Surprise Billing Claims by providers, including information on how to contact state and federal agencies if you believe a provider has violated the No Surprises Act.

You may also obtain the following information on the Included Health website or by calling the phone number on the back of your ID Card:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and

- A listing / directory of all Preferred Providers.

In addition, Blue Shield of California will provide access through its website to the following information:

- Preferred Provider negotiated Rates; and
- Historical Non-Preferred Provider Rates.

Your Introduction to the PERS Gold Basic PPO Health Plan

Welcome to your Preferred Provider Organization (PPO) Plan. In a PPO plan, you have the flexibility to choose the providers you see. You can receive care from Preferred Providers or Non-Preferred Providers. See the How to Use This Plan section for information about Preferred and Non-Preferred Providers.

The term "Member" is used throughout this booklet to mean employees or retirees and their Family members and/or domestic partners who are enrolled in this PPO Plan through CalPERS.

Optum Rx® provides Prescription Drug benefit management services for PERS Gold. These services include administration of the Retail Pharmacy Program and the Home Delivery Program; delivery of specialty pharmacy products such as specialty pharmaceuticals and injectables; clinical pharmacist consultation; and clinical collaboration with your Physician to ensure you receive optimal total healthcare.

CalPERS has partnered with Included Health to provide Population Health Management services for PERS Gold, including Member services and Member advocacy, care navigation, care and case management, expert medical opinion, and virtual primary care and virtual behavioral health services. Included Health is here to answer any questions you might have about your health care or health plan.

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

Thank you for joining PERS Gold!

Contact Information

For questions about coverage details, deductibles, out-of-pocket expenses, medical claims status, claim forms, and identification cards, please contact:

Included Health
855-633-4436
includedhealth.com/calpers
or message the team using the Included Health mobile app.
Toll-free text telephone (TTY): 711

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

Blue Shield of California
P.O. Box 272540
Chico, CA 95927

THIS IS ONLY A BRIEF SUMMARY OF COVERED SERVICES. REFER TO THE BENEFIT DESCRIPTIONS AND
LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

PERS Gold Summary of Benefits

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

Calendar Year Deductible:

For each Plan Member:

- Preferred Providers: $500
- Non-Preferred Providers: $2,500

For each Plan Member Inpatient Care: $500

For each Family:
Preferred Providers: $2,000
Non-Preferred Providers: $5,000

(See the Calendar Year Deductible section for services not subject to the Deductible.)

Maximum Calendar Year Coinsurance Responsibility for Preferred Provider (PPO) Services
For each Plan Member: $3,000
For each Family: $6,000

You will receive a credit for your $500 Inpatient Care Calendar Year Deductible towards Preferred Providers only if you complete the following activities:
1. Preventive Screening: $100 Deductible Credit
2. Flu Shot: $100 Deductible Credit
3. Non-Smoking Certification: $100 Deductible Credit
4. Second Opinion: $100 Deductible Credit
5. Care and Case Management participation: $100 Deductible Credit

All preventive care screenings will count towards the preventive screening credit. Any flu shot within the past 18 months will be credited in the Calendar Year. Non-Smoking credit will be given unless you are identified as a smoker. Second opinion will be credited unless you have surgery without a second opinion. Care and Case Management participation will be credited unless you are contacted by a nurse and decline to participate in Included Health's Care Management program.

Dependents of any age (other than a spouse or domestic partner) will automatically receive all five credits applied at the beginning of the year.

If you qualify for all five credits, your 2025 in-network deductible will be:

- $500 for an individual (instead of $1,000).
- $1,000 for a Family (instead of $2,000).

Eligibility and Enrollment

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

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

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

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

Included Health

We recommend activating your Included Health service as soon as possible. It's included with your Benefits. You can activate your account by downloading the Included Health mobile app or online at includedhealth.com/calpers.

Monthly Rates

State Employees and Annuitants

The Rates shown below are effective January 1, 2025 and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	$943.70
Employee and one dependent	$1,887.40
Employee and two or more dependents	$2,453.62

Contracting Agency Employees and Annuitants

The Rates charged are based on the pricing region in which the employee/annuitant resides. See below for a description of the pricing region. If the employee/annuitant lives outside of the Plan's service area and is enrolled based on place of employment, then the pricing region for the place of employment will apply. The Rates shown below are effective January 1, 2025 and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among public agencies. For assistance calculating your net contribution, contact your agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	
Region 1	$1,013.70
Region 2	$864.75
Region 3	$868.15
Employee and one dependent	
Region 1	$2,027.40
Region 2	$1,729.50
Region 3	$1,736.30
Employee and two or more dependents	
Region 1	$2,635.62
Region 2	$2,248.35
Region 3	$2,257.19

Pricing Regions for Contracting Agency Employees and Annuitants

[1] Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba

[2] Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura

[3] Los Angeles, Riverside, and San Bernardino

Out-of-California. The PERS Gold Basic Supplemental Plan is not available to out-of-state Employees and Annuitants.

Rate Change

The plan Rates may be changed as of January 1, 2026, following at least 60 days' written notice to the Board prior to such change.

PERS Gold Identification Card

Following enrollment in PERS Gold, you will receive a PERS Gold ID card. To receive medical services and Prescription Drug Benefits as described in the Plan, please present your ID Card to each provider of service. If you need a replacement card or a card for a Family Member, contact Included Health at 855-633-4436.

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

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

If you do not receive your identification card or if you need to obtain medical services before your card arrives, contact Included Health so that they can coordinate your care and direct your Physician.

How to Use the Plan

Preferred Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

The PERS Gold Basic PPO Plan provides you the flexibility to choose the providers you see. You can receive care from Preferred Providers or Non-Preferred Providers. Preferred Providers are listed in the CalPERS PPO Physician and Hospital Directory. Provider directories frequently change; it is your obligation to be sure that the provider you choose is a Preferred Provider by asking your Physician or the provider you choose to utilize if he or she is a Preferred Provider and request their tax identification number (TIN). Then contact Included Health to verify whether the TIN is a Preferred Provider with Blue Shield of California. To verify the in-network status of providers, use the Included Health mobile app to search for providers by name. One week prior to your appointment, call Included Health to confirm the specific provider is in-network with your plan (855-633-4436).

Non-Preferred Providers

Non-Preferred Providers do not have a contract with Blue Shield of California to accept the Allowable Amount as payment in full for Covered Services. Except for Emergency Services, services received at a Preferred Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other Outpatient settings) under certain conditions, you will pay more for Covered Services from a Non-Preferred Provider.

Non-Preferred Providers at a Preferred Provider Hospital or Ambulatory Surgery Center
When you receive care at a Preferred Provider facility, some Covered Services may be provided by a Non-Preferred Provider. Your Cost Share will be the same as the amount due to a Preferred Provider under similar circumstances, and you will not be responsible for additional charges above the Allowable Amount, unless the Non-Preferred Provider provides you written notice of what they may charge and you consent to those terms.

Your Primary Care Physician

You are required to have a Primary Care Physician (PCP). However, you do not need to visit your PCP or get a referral from your PCP before you receive care.

We do suggest your Chosen PCP be your first point of contact when you need Covered Services. Your Chosen PCP can provide primary care and help direct you to specialized care.

We encourage you to select a PCP at the time of enrollment. If a PCP is not selected, the Plan will choose a PCP for you. If you are assigned a PCP by the Plan, you have the ability to change your PCP at any time. To change your Chosen PCP, visit includedhealth.com/calpers.
PCPs may be:

- General practitioners;
- Family practitioners;
- Internists;
- Obstetrician/gynecologists; or
- Pediatricians.

You do not need to choose the same PCP for each Member in your Family.

How to Use the Plan

Your Chosen PCP must be a Preferred Provider within the PPO network. If your Chosen PCP leaves this plan's network, The Plan will choose a new PCP for you and notify you.

Virtual Primary Care

You can select a designated virtual primary care Physician through the Included Health app or website.

Virtual primary care is designed to support, not replace, in-person primary care.
Virtual Health Care Providers can help you with:

- Preventive care
- Urgent care
- Assessment and treatment of acute and chronic conditions
- Follow up care
- Writing and refilling prescriptions
- Care Coordination and referrals.
- Managing and developing strategies to reduce chronic disease

To find more information, call 855-633-4436 or visit includedhealth.com/calpers.

Finding a Provider Online

Ask your Physician or the provider you choose to utilize if he or she is a Preferred Provider and request their tax identification number (TIN). Then contact Included Health to verify whether the TIN is a Preferred Provider with Blue Shield of California. You can find providers using the mobile app or visit Included Health and log in to your account. Here's how:

1. Download the Included Health app.
2. Activate your account if you haven't done so yet.
3. On the home screen, select *Search for Local Care.*
4. Select *Search for providers.*
5. Enter the specialty, condition, or provider you are looking for, or select one of the common search topics.
6. You'll see a list of recommended providers on the following page, as well as additional details, including their address and whether they are a Preferred Provider.

Continuity of Care

Continuity of care with a Non-Preferred Provider may be available if your provider leaves Blue Shield of California network or Blue Shield of California no longer contracts with your Preferred Provider for the services you are receiving.

Continuity of care may also be available to you when your Employer terminates its contract with Blue Shield of California and contracts with a new third-party administrator (TPA) that does not include Blue Shield of California's Preferred Provider in its network.

If your Former Preferred Provider is no longer available to you for one of the reasons noted above, Blue Shield of California will notify you of the option to continue treatment with your Former Preferred Provider.

You can request to continue treatment with your Former Preferred Provider in the situations described above if you are currently receiving the following care:

Continuity of care with a Former Preferred Provider	
Qualifying Conditions	**Timeframe**
• Ongoing treatment for a serious and complex condition; • Ongoing institutional or Inpatient care; • Ongoing pregnancy care, including care immediately after giving birth; • Scheduled, nonelective surgery, including postoperative care; or • Treatment for a terminal illness	90 days from the date you were notified that the Former Preferred Provider is no longer available to you or until the treatment concludes, whichever is sooner

In addition, continuity of care may be available to you if your Former Preferred Provider is no longer available to you due to the transition from the former Third-Party Administrator or Plan to Blue Shield of California effective January 1, 2025. Contact Included Health at includedhealth.com/calpers or 855-633-4436 to discuss your continuity of care options resulting from the transition.

To request continuity of care with a Former Preferred Provider, visit includedhealth.com/calpers or call Included Health at 855-633-4436to receive help with the Continuity of Care Application. Blue Shield of California will confirm your eligibility and may review your request for Medical Necessity.

The Former Preferred Provider must accept Blue Shield of California's Allowable Amount as payment in full for your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Preferred Provider at the Preferred Provider Copayment or Coinsurance.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Preferred Provider in the same geographic area.

How to Receive Care

How to Use the PERS Gold Basic PPO Plan

When you need health care, present your Member identification card to your Physician, Hospital or other licensed Health Care Provider. Your identification card has your Participant and group number on it.

Prior Authorization

If you see a Preferred Provider, your provider must obtain prior authorization when required. When prior authorization is required but not obtained, Blue Shield of California may deny payment to your provider. You are not responsible for Blue Shield of California's portion of the Allowable Amount if this occurs, only your Cost Share.

If you see a Non-Preferred Provider, you or your provider must obtain prior authorization when required. When prior authorization is required but not obtained, and the services provided are determined not to be a Benefit of the plan or Medically Necessary, Blue Shield of California may deny payment and you will be responsible for all billed charges.

How to Use the Plan

For questions or more information, visit includedhealth.com/calpers or call 855-633-4436 to get help with details about medical and surgical services that require prior authorization.

For services and supplies listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a covered service and may also receive a recommendation for an alternative service.

For services other than those listed in the sections below, you, your dependents or provider should consult the Benefit Descriptions section of this booklet to determine whether a service is covered.

Your Physician must call Blue Shield of California for prior authorization for the services listed in this section except for Outpatient radiological procedures. For prior authorization for Outpatient radiological procedures, your Physician must call 888-642-2583.

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

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

Prior authorization is required no later than 5 business days prior to the start of the following procedures, services and surgeries or purchase of Durable Medical Equipment. Services for which prior authorization is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

1. Inpatient hospitalization.
2. Acute Inpatient rehabilitation.
3. Skilled Nursing Facility.
4. All Inpatient mental health or substance use disorder treatment
5. All Outpatient Facility-based care for mental health or substance use disorder treatment
6. Temporomandibular disorder treatment and diagnostic services, including MRIs and surgeries
7. Maxillomandibular musculoskeletal surgeries.
8. Septoplasty and sinus-related surgery.
9. Specific Durable Medical Equipment (see Section E.).
10. Bariatric surgeries.
11. Any plastic or reconstructive procedures/surgeries.
12. Skin transplants.
13. Any anesthesia administered by an anesthesiologist or nurse anesthetist during a colonoscopy.
14. Hip and knee joint replacement surgeries.
15. Additional Physical Therapy and Occupational Therapy visits beyond those provided under the Plan.
16. Additional Speech Therapy visits beyond those provided under the Plan.
17. Transgender surgery including travel expense.
18. Hepatic Activation/Chronic Intermittent Intravenous Insulin Infusion Therapy/Pulsatile Intravenous Insulin Infusion Therapy Treatments.

Other specific services and procedures may require prior authorization as determined by Blue Shield of California. A list of services and procedures requiring prior authorization can be obtained by your provider by calling Blue Shield of California.

Hospital and Skilled Nursing Facility Admissions
Prior authorization must be obtained from Blue Shield of California for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are hospitalizations for continuing Inpatient rehabilitative and skilled nursing care.

Prior Authorization for Other than Mental Health or Substance Use Disorder Services
Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, your Physician must contact Blue Shield of California at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, Blue Shield of California should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Blue Shield of California will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this health plan that the services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Prior Authorization for Inpatient Mental Health or Substance Use Disorder Services
Prior authorization is required for all nonemergency Mental Health Hospital admissions including acute Inpatient care and Residential Care. Other Outpatient Mental Health Services include Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing, and Transcranial Magnetic Stimulation (TMS) and must also be prior authorized.

For an admission for emergency mental health or substance use disorder services, Blue Shield of California should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

Failure to contact Blue Shield of California as described above or failure to follow the recommendations of Blue Shield of California may result in non-payment by Blue Shield of California if it is determined that the admission is not a covered service.

Blue Shield of California will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Participant within 2 business days of the decision. For

Urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Blue Shield of California will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

If prior authorization is not obtained for a mental health Inpatient admission or for any Other Outpatient Mental Health Services and the services provided to the Member are determined not to be a Benefit of the plan, coverage will be denied.

Prior authorization is not required for an emergency admission.

Emergency Admission Notification
If you are admitted for Emergency Services, Blue Shield of California should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

Hospital Inpatient Review
Blue Shield of California monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of Hospital stays will be determined solely by your Physician in consultation with you. When a determination is made that the Member no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Physician or other Health Care Provider. You will be responsible for any Hospital charges incurred beyond 24 hours of receipt of notification.

Discharge Planning
If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield of California may work with you, your Physician and the Hospital discharge planners to determine whether Benefits are available under this Plan to cover such care.

Second Medical Opinions

If you have a question about your diagnosis or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Included Health's Expert Medical Opinion is a second opinion service where an expert clinician provides a review of a diagnosis or treatment plan, which originated from one of your treating providers, for the purpose of helping Members understand their options. It's recommended to get a second opinion before moving forward with any surgery. In order to get a $100 deductible credit towards your Inpatient Care Calendar Year Deductible, a second opinion prior to surgery must be obtained.

A Care Coordinator will collect your relevant medical records, which will be reviewed by the second opinion Physician. Copies of the opinion will be provided to you and your treating Physician(s), followed by a follow-up to ensure understanding and address any questions, with additional direct follow-up from the clinician if necessary.

Visit includedhealth.com/calpers and log in to your account, or call 855-633-4436 to connect with a member of the Included health care team about this option.

24/7 Healthcare Advice

As part of your enrollment in the PERS Gold plan, you have access to Included Health's healthcare navigation service available 24/7 in the Included Health mobile app, over the phone, or online at includedhealth.com/calpers. Additionally, you have access to 24/7 telephonic support from nurses who can help direct you to the next clinically appropriate step, whether it be at-home care, urgent in-person care, or other health care services.

Included Health provides a toll-free phone line where registered nurses are available to answer your medical questions 24 hours a day, seven days a week. Call 855-633-4436, visit includedhealth.com/calpers, or download the Included Health app to get started. You must activate your Included Health account first in order to speak with a nurse.

Care and Case Management

Your Plan includes Care and Case Management to help you better understand and manage specific acute and chronic health conditions such as asthma, diabetes, heart disease, and autoimmune conditions like multiple sclerosis. It provides education to help you better manage and monitor your condition.

- Case Management: Offers comprehensive support services to help Members navigate acute medical events, such as surgeries and hospitalizations. Our team ensures that Members receive the necessary care and resources during these critical times.

- Care Management: Delivers longitudinal clinical Care Coordination for Members with complex health needs. This includes an initial assessment, personalized care planning, education, and ongoing clinical guidance. Care plans are holistic, incorporating relevant services from Included Health to ensure seamless and effective care management. This program is designed to support Members throughout their healthcare journey, providing the necessary tools and support for optimal health outcomes. See below for more details.

Care and Case Management offer the following:

- Custom care plan for your specific health condition(s).
- Clinical support from primary care doctors and specialists for your condition—whether virtual or in-person.
- 24/7 Care Coordination support to help you navigate your plan.
- Depression screening

You may be identified for participation through claims history, Hospital discharge reports, Physician referral, or case management, or you may request to participate by calling Included Health at 855-633-4436. Participation is voluntary and confidential. Care and Case Management are available at no cost to you. Once identified as a potential participant, an Included Health representative will contact you. If you choose to participate, 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.

Care and Case Management offer you assistance and support in improving your overall health. It is not a substitute for your Physician's care.

Retail-Based Health Clinics

Retail-based health clinics are conveniently located within stores and pharmacies. They are staffed with nurse practitioners who can provide basic medical care on a walk-in basis.

The Cost Share for Covered Services at a Participating retail-based health clinic is the same as the Cost Share at a Physician's office.

Emergency Services

The Member must notify Included Health by phone within 24 hours of an emergency admission or as soon as medically possible following the admission.

An emergency means an unexpected medical condition, including a psychiatric Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a layperson who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part. If you receive non-authorized services in a situation that Blue Shield of California determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

What to do in case of Emergency:

Life Threatening

Obtain care immediately.

Contact your Personal Physician no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening

Consult your Personal Physician, anytime day or night, regardless of where you are prior to receiving medical care.

Follow-Up Care

Follow-up care is any care provided after the initial emergency room visit.

For a complete description of the Emergency Services Benefit and applicable Copayments, see I. Emergency Services in the Benefit Descriptions section.

Urgent care centers

Urgent care centers are free-standing facilities that are not affiliated with or part of a Hospital that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

Site of Care Coordination

For selected clinician-infused Specialty Medications, nurses from Optum® Specialty Pharmacy will assist you with coordinating care with the nursing agency to deliver and administer the Drugs to you according to your Physician's order. Optum® Specialty Pharmacy nurses continuously communicate with you to confirm the care is meeting your individual needs. Resources are also provided for non-English speaking and hearing-impaired Members.

Service Areas

Qualifying Out-of-Area Zip Codes

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

This Plan has established geographic service areas to determine the percentage of reimbursement for covered medical and Hospital services. The Benefits available through this Plan depend on whether you and your Family use Preferred Providers, and whether you are in-area or Out-of-Area. To determine if your provider is in-area or Out-of-Area, contact Included Health at 855-633-4436. Reimbursement for Covered Services also depends on whether you are in-area or Out-of-Area.

When a Preferred Provider is not available within a 50-mile radius of your residence or workplace, you must obtain prior authorization before receiving services by a Non-Preferred Provider in order for that service to be paid at the Preferred Provider percentage of the Allowed Amount. To obtain prior authorization, your Physician must call Blue Shield of California at least 3 business days prior to scheduling an admission to, or receiving the services of, a Non-Preferred Provider. If you have received prior authorization, your claim will automatically be paid at the Preferred Provider percentage of the Allowed Amount. You are responsible to pay the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

If prior authorization is NOT obtained prior to services being provided, your claim will automatically be paid at the Non-Preferred Provider level. Upon receipt of your Explanation of Benefits (EOB), contact Included Health at 1-855-633-4436 to request that your claim be reprocessed at the Preferred Provider level. You are responsible to pay the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

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

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

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

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

To find out if you are considered Out-of-Area, please call Included Health at 855-633-4436.

Out-of-State/Out-of-Country BlueCard Program

Members in Out-of-Area zip codes are eligible for Included Health virtual care services. Use the Included Health app to find and connect with a provider. To connect with an Included Health virtual provider:

1. Download the Included Health app.
2. Activate your account if you haven't done so yet.
3. On the home screen, select *Virtual Care.*
4. Select *Urgent care* or *Primary care* depending on your care need.
5. Follow the page-by-page instructions.
6. Once you've completed the intake instructions, you will be connected with the next available provider.

Overview

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will receive care from one of two kinds of providers. Preferred providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Non-preferred providers don't contract with the Host Blue. PERS Gold Basic payment practices in both instances are described in this section.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard® Program

Under the BlueCard® Program, Benefits will be provided for Covered Services received outside of California, but within the BlueCard® Service Area. When you receive Covered Services within the geographic area served by a Host Blue, PERS Gold will remain responsible for the provisions of this Plan. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Health Care Providers, including direct payment to the provider.

When you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for these services, if not a flat dollar Copayment, is calculated based on the lower of:

1. The billed charges for Covered Services; or

2. The negotiated price that the Host Blue makes available to PERS Gold.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Health Care Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a

discount that results in expected average savings for similar types of Health Care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing as noted above. However, such adjustments will not affect the price PERS Gold uses for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard® providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at bcbs.com and select "Find a Doctor."

Prior authorization may be required for non-emergency services. Please see the Prior Authorization section for additional information on prior authorization and the Emergency Admission Notification section for information on emergency admission notification.

Non-preferred Providers Outside of California
When Covered Services are provided outside of California and within the BlueCard Service Area by non-preferred providers, the amount you pay for such services will normally be based on either the Host Blue's non-preferred provider local payment, the Allowable Amount PERS Gold pays a Non-Preferred Provider in California if the Host Blue has no non-preferred provider allowance, or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-preferred provider bills and the payment PERS Gold will make for Covered Services as described in this paragraph.

If you do not see a preferred provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Blue Shield of California for reimbursement. Blue Shield of California will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-preferred provider.

Your cost share for out-of-network Emergency Services will be the same as the amount due to a Preferred Provider for such Covered Services, as listed in the Summary of Covered Services.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services outside the BlueCard Service Area
If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global® Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global® Core is unlike the BlueCard® Program available within the BlueCard® Service Area in certain ways. For instance, although Blue Shield Global® Core assists you with accessing a network of Inpatient, Outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from provider outside the BlueCard® Service Area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a

week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global® Core".

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please see the Emergency Admission Notification section for information on emergency admission notification.

Submitting a Blue Shield Global® Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. The claim form is available from Included Health at 855-633-4436 or includedhealth.com/calpers, or the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Claims will be accepted for U.S. residents who are traveling in foreign countries for urgent or emergent care only. Claims for elective procedures will not be reimbursed. Members who temporarily reside in foreign countries may submit claims for routine, elective procedures, urgent and emergent care to Blue Shield of California. See Submitting Foreign Claims below for information on foreign claims submission.

Submitting Foreign Claims

Foreign Medical Claims: The Benefits of this Plan are provided anywhere in the world. With the exception of services provided by a Hospital participating in the BlueCross BlueShield Global Core Network (see above), if you are traveling or reside in a foreign country and need medical care, you may have to pay the bill and then be reimbursed. You should ask the provider for an itemized bill (written in English).

Members Who Are Traveling Out-of-Country

Claims will be accepted for U.S. residents who are traveling in foreign countries for Urgent Care or Emergency Services only. Claims for elective procedures will not be reimbursed. If you receive Urgent Care or Emergency Services, you must complete a claim form, which can be found on the BlueCross BlueShield Global Core Web site at www.bcbsglobalcore.com. The completed claim form and supporting information must then be submitted directly to Blue Shield of California at: P.O. Box 272540, Chico, CA 95927 or to Global Core's address located on the claim form.

Members Who Reside Out-of-Country

When you receive Covered Services while residing out-of-country, you must complete a claim form, which can be found on the BlueCross BlueShield Global Core Website at www.bcbsglobalcore.com. The completed claim form and supporting information must then be submitted directly to Blue Shield of California at: P.O. Box 272540, Chico, CA 95927 or to Global Core's address located on the claim form.

How Foreign Claims Are Processed For Payment

Members traveling or residing outside the United States shall be considered "Out-of-Area." Covered Services for these Members will be reimbursed at the higher Preferred Provider Benefit level based on the Allowable Amount. Please note, in addition to your Deductible and Coinsurance, you may be required to pay for charges which are in excess of the Allowable Amount.

Special Cases: Value-Based Programs

Out-of-State/Out-of-Country BlueCard Program

You may have access to Covered Services from providers that participate in PERS Gold Value-Based Programs. PERS Gold Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes, and Shared Savings arrangements.

If you receive Covered Services under a Value-Based Program, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement.

BlueCard® Program
If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Plan through average pricing or fee schedule adjustments.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of PERS Gold's Allowable Amount.

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.

Allowable Amount

The Allowable Amount is the maximum amount the Plan will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. The Plan's payment to the provider is the difference between the Allowable Amount and your Cost Share.

Preferred Providers agree to accept the Allowable Amount as payment in full for Covered Services, except as stated in the Exception for Other Coverage and Payment by Third Parties sections. When you see a Preferred Provider, you are responsible for your Cost Share.

Generally, the Plan will pay its portion of the Allowable Amount and you will pay your Cost Share. If there is a payment dispute between the Plan and a Preferred Provider over Covered Services you receive, the Preferred Provider must resolve that dispute with the Plan. You are not required to pay for the Plan's portion of the Allowable Amount. You are only required to pay your Cost Share for those services.

Non-Preferred Providers do not agree to accept the Allowable Amount as payment in full for Covered Services. When you see a Non-Preferred Provider, you are responsible for:

- Your Cost Share; and;
- All charges over the Allowable Amount.

For help understanding what's covered, what's not, and what costs you're responsible for, contact an Included Health Care Coordinator. You can message a Care Coordinator in the Included Health mobile app, or call 855-633-4436 to speak over the phone, or chat in a web browser. They offer guidance, support, and advocacy 24/7/365.

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Services before the Plan begins payment. Blue Shield of California will pay for some Covered Services before you meet your Deductible.

Amounts you pay toward your Deductible count toward your Out-of-Pocket Maximum. The Preferred Provider Deductible applies toward the Calendar Year Out-of-Pocket Maximum, but the Non-Preferred Provider Deductible does not apply to the Calendar Year Out-of-Pocket Maximum.

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

After the Calendar Year Deductible and any other applicable Deductible are satisfied, payment will be provided for Covered Services. The Calendar Year Deductible, however, does not apply to some services (see the list below). The Deductible must be made up of charges for services covered by the Plan in the

Calendar Year in which the services are provided. The Calendar Year Deductible applies separately to each Plan Member and is accumulated in the order in which claims processing has been completed.

For Preferred Providers, the Calendar Year Deductible is $500 and the Inpatient Care Calendar Year Deductible is $500 for each Plan Member, and $2,000 per Family. The Preferred Provider Calendar Year Deductible applies toward the Maximum Calendar Year Medical Financial Responsibility.

For Non-Preferred Providers, the Calendar Year Deductible is $2,500 for each Plan Member and $5,000 per Family. The Non-Preferred Provider Calendar Year Deductible does not apply toward the Maximum Calendar Year Medical Financial Responsibility.

Charges will be applied to the Deductible beginning on January 1, 2025, and will extend through December 31, 2025. Some services, however, are not subject to the Deductible.

If your plan has Family coverage, there is an individual Deductible within the Family Deductible. This means an individual Family Member can meet the individual Deductible before the entire Family meets the Family Deductible.

If your plan has individual coverage and you enroll a Dependent, your Plan will have Family coverage. Any amount you have paid toward the Deductible for your plan with individual coverage will be applied to both the individual Deductible and the Family Deductible for your new Plan.

The Calendar Year Deductible does NOT apply to the following:

- Physician office, Outpatient Hospital and Urgent Care visits and consultations provided by Preferred Providers.
- Physician office visits provided by Preferred Providers in a Retail-Based Health Clinic.
- Diabetes self-management education program services received from Preferred Providers.
- Immunizations received from Preferred Providers.
- Preventive Care Services received from Preferred Providers.
- Inpatient Hospital Facility charges, including Alternative Birthing Centers.
- Childbirth classes.
- Smoking cessation programs.
- Online Visits provided by Preferred Providers.
- Chiropractic care and acupuncture services provided by Preferred Providers.

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

To view the status of your Deductible, use the Included Health app or log in to your account by visiting includedhealth.com/calpers.

Member Calendar Year Out-of-Pocket Maximum

For services provided by Preferred Providers, the out-of-pocket maximum for medical expenses will be $7,200 per individual and $14,400 per Family. Your maximum Calendar Year Coinsurance Responsibility will be $3,000 per individual and $6,000 per Family.

Once a Member's maximum Copayment responsibility has been met, the Plan will pay 100% of the Allowable Amount for that Member's Covered Services for the remainder of that Calendar Year, except as

described below. Additionally, for Plans with a Member and a Family maximum Copayment responsibility, once the Family maximum Copayment responsibility has been met, the Plan will pay 100% of the Allowable Amount for the Participant's and all covered dependents' Covered Services for the remainder of that Calendar Year, except as described below.

Covered Services received at a facility that is a Preferred Provider will accrue to the Calendar Year Out-of-Pocket Maximum whether Services are provided by a health professional who is a Preferred Provider or Non-Preferred Provider.

Note that Copayments and charges for services not accruing to the Member Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Maximum Calendar Year Coinsurance Responsibility

When Covered Services are received from a Preferred Provider, or if you live and receive Covered Services outside a Preferred Provider service area, your maximum Calendar Year Coinsurance responsibility is three thousand dollars ($3,000) per Member, not to exceed six thousand dollars ($6,000) per Family. In most circumstances, once you incur expenses equal to those amounts, you will no longer be required to pay a Coinsurance for the remainder of that year provided you receive covered medical services from a Preferred Provider or if you live and received Covered Services outside a Preferred Provider service area. You do, however, remain responsible for costs in excess of any specified Plan maximums and for services or supplies which are not covered under this Plan.

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

Exceptions:

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

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

The following are not included in calculating your maximum Calendar Year Coinsurance responsibility. You will continue to be responsible for these charges even after you have reached the Calendar Year Coinsurance or Out-of-Pocket Maximum:

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

Claims

When you receive health care services, a claim must be submitted to request payment for Covered Services. A claim must be submitted even if you have not yet met your Deductible. PERS Gold uses claims information to track dollar amounts that count toward your Deductible and Out-of-Pocket Maximum.

When you see a Preferred Provider, your provider submits the claim to Blue Shield of California. When you see a Non-Preferred Provider, you must submit the claim to Blue Shield of California. Claim forms are available at includedhealth.com/calpers.

For questions and assistance about the claims process, contact Included Health by calling 855-633-4436 or using the Included Health mobile app. Included Health can help you submit your claim to Blue Shield of California.

How to Submit a Claim

Please submit a medical services claim, including Blue Shield of California claim form and the itemized bill from your provider, to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927
Online at: includedhealth.com/calpers

All claims are due within one year of the service date.

Claim processing and payments

Blue Shield of California will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield of California cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by PERS Gold to the provider.

When you receive Covered Services from a Non-Preferred Provider, Blue Shield of California may send the payment to the Participant, or directly to the Non-Preferred Provider.

Note: The Participant must make sure the Non-Preferred Provider receives the full billed amount for non-emergency services, whether or not Blue Shield of California makes payment to the Non-Preferred Provider.

Claims Advocacy

Included Health offers claims advocacy and support, to help with billing and claims issues and to help you understand Coinsurance and Copayment responsibilities. Start a claims inquiry with Included Health via the mobile app, includedhealth.com/calpers, or over the phone.

Limitation of Liability

Members shall not be responsible to Preferred Providers or health professionals who are Non-Preferred Providers rendering Services at a Preferred Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other Outpatient settings) for payment for services if they are a Benefit of the Plan, unless the Non-Preferred Provider provides the Member with written notice of what they may charge and the Member consents to those terms. When Covered Services are rendered by a Preferred Provider or rendered by a health professional who is a Non-Preferred Provider at a Preferred Provider facility, the Member is responsible only for the applicable Copayments, except as set forth in the "Third Party Recovery Process and the Member's Responsibility" section. Members will not be responsible for additional charges above the Allowable Amount without written notice and consent. Members are responsible for the full charges for any non-covered services they obtain.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield of California will have the right to recover such payment from the Participant or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, Blue Shield of California reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of Benefits in excess of the Benefits provided by the health plan, payment of amounts that are the responsibility of the Participant or Member (Deductibles, Copayments, Coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant or Member's eligibility, or payments on fraudulent claims.

Expedited Decision

Blue Shield of California has established a procedure for our Members to request an expedited decision (including those regarding Grievances). A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield of California shall make a decision and notify the Participant and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other health care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Included Health at 855-633-4436.

Benefit Descriptions

The Plan Benefits available to you are listed in this section. The Copayments for these services, if applicable, follow each Benefit description.

The following are the basic health care services covered by the Plan and as set forth in the "Third Party Recovery Process and the Member's Responsibility" section. These services are covered when Medically Necessary. Coverage for these services is subject to the Benefits Management Program and all terms, Benefit descriptions below, and to the Exclusions and Limitations set forth in this booklet.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

For additional information on your medical and Hospital Benefits, use the Included Health app to see your plan info, including Out-of-Pocket Maximum, Copayments, and Coinsurance. Download the Included Health app, visit includedhealth.com/calpers, or call 855-633-4436 to get started. If you have questions about your Benefits, contact Included Health before Hospital or medical services are received.

A. Hospital Services

The following Hospital services customarily furnished by a Hospital will be covered when Medically Necessary and authorized.

1. Inpatient Hospital services

80% Preferred Provider
60% Non-Preferred Provider

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

Hip and Knee Joint Replacement Surgery

80% Value Based Purchasing Design for Hip and Knee Joint Replacement and Out-of-Area
60% Non-Preferred Provider

The Benefit maximum for Inpatient services provided for hip and knee joint replacement is $35,000 per procedure. Only the claim submitted by the Hospital is subject to the Benefit maximum. PERS Gold has developed a list of Value Based Purchasing Design Hospitals that routinely provide this service below this threshold. Please contact Included Health or visit includedhealth.com/calpers to verify that the Hospital qualifies under the Hip and Knee Joint Replacement for Value Based Purchasing Design and will provide services within this limitation.

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

Prior authorization must be obtained as soon as possible, but no later than 3 business days prior to the commencement of services. Failure to obtain prior authorization under the terms and conditions specified in this Plan and within the specified time frame may result in increasing your

Coinsurance and liability responsibility by the application of financial sanctions and/or denial of Benefits.

Travel and lodging expenses may also be covered when necessary to obtain Covered Services and authorized in advance by the Plan. See Section V. 7. Travel and Lodging Benefits for more information.

2. Outpatient Hospital services

80% Preferred Provider
60% Non-Preferred Provider

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

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

The following are considered routine services and can be performed safely at an Ambulatory Surgery Center. If these routine procedures are performed in an Ambulatory Surgery Center (as defined in the EOC), Benefits will be paid according to the Plan (see Ambulatory Surgery Centers Benefit).

Upper gastrointestinal endoscopy	Tonsillectomy and/or adenoidectomy (for Members under age 12)
Upper gastrointestinal endoscopy (with biopsy)	Lithotripsy - fragmenting of kidney stones
Laparoscopic gall bladder removal	Hernia inguinal repair (Member over age 5, non-laparoscopic)
Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage)	Esophagoscopy
Nasal/sinus corrective surgery - septoplasty	Repair of laparoscopic inguinal hernia
Nasal/sinus - submucous resection inferior turbinate	Sigmoidoscopy services

Blue Shield of California has a network of Ambulatory Surgery Centers that generally provide these services within the maximum Benefit amount. No Benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Included Health to verify that the facility is listed as a preferred Ambulatory Surgery Center in Blue Shield of California's network.

If these routine services are provided in an Outpatient Hospital Setting, without an approved exception form, the following maximums will apply:

- Colonoscopy services are limited to **a maximum payment of $1,500** per procedure.
- Cataract surgery services are limited to **a maximum payment of $2,000** per procedure.
- Arthroscopy services are limited to **a maximum payment of $6,000** per procedure.
- Services for upper gastrointestinal endoscopy with biopsy are limited to **a maximum payment of $2,000** per procedure.
- Laparoscopic gall bladder removal services are limited to **a maximum payment of $5,000** per procedure.
- Upper gastrointestinal endoscopy services are limited to **a maximum payment of $1,500** per procedure.
- Services for hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage) are limited to **a maximum payment of $3,500** per procedure.
- Nasal/Sinus - submucous resection inferior turbinate services are limited to **a maximum payment of $3,000** per procedure.

3. Ambulatory Surgery Centers

100% Preventive care, Preferred Provider and Out-of-Area
80% Preferred Provider, Diagnostic colonoscopy services
60% Non-Preferred Provider

Except for Preventive Health Benefits, Ambulatory Surgery Center services are subject to the Calendar Year Out-of-Pocket Maximum; however, services received from Non-Preferred Providers have no Cost Share limits.

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

The following are considered routine services and can be performed safely at an Ambulatory Surgery Center. If these routine procedures are performed in an Ambulatory Surgery Center, Benefits will be paid according to the Plan:

- Upper gastrointestinal endoscopy
- Tonsillectomy and/or adenoidectomy (for Members under age 12)
- Upper gastrointestinal endoscopy (with biopsy)
- Lithotripsy - fragmenting of kidney stones
- Laparoscopic gall bladder removal
- Hernia inguinal repair (Member over age 5, non-laparoscopic)
- Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage)
- Esophagoscopy
- Repair of laparoscopic inguinal hernia
- Nasal/sinus corrective surgery - septoplasty
- Nasal/sinus - submucous resection inferior turbinate
- Sigmoidoscopy services

Please contact Included Health or visit includedhealth.com/calpers to verify that the Ambulatory Surgery Center is a Preferred Provider.

Please see the Prior authorization section for guidelines for prior authorization of non-emergency procedures. Generally, various non-emergency procedures, services, and surgeries require prior authorization. Prior authorization is required at least 5 business days before admission for nonemergency Inpatient services and at any time prior to the service of certain imaging procedures. Failure to obtain prior authorization under the terms and conditions specified in this Plan and within the specified time frame may result in denial of payment to your provider.

4. Bariatric Surgery

80% at Blue Distinction Centers for Specialty Care
80% for Physicians on surgical team at designated Blue Distinction Centers for Specialty Care

Prior authorization for all bariatric surgical procedures must be obtained from Blue Shield of California as soon as possible, but no later than 3 business days before services are provided. Failure to obtain prior authorization under the terms and conditions specified in this Plan and within the specified time frame may result in denial of payment to your provider. For questions about the prior authorization process, contact Included Health at 855-633-4436.

Services and supplies provided in connection with Medically Necessary bariatric surgery for treatment of morbid obesity are a Benefit only when the procedure is in accordance with the Plan's Medical Policy, prior authorization has been obtained, and services are performed at a designated Blue Distinction Centers for Specialty Care (BDCSC). Services provided for or in connection with a bariatric surgical procedure performed at a facility other than a designated (BDCSC) will not be covered.

BDCSC agrees to accept the Allowable Amount as payment for Covered Services. Plan Members are responsible for the remaining 20% of the lesser of Billed Charges or the Allowable Amount for Covered Services and all charges for non-covered services. Please notify Included Health at 855-633-4436 as soon as your provider recommends a bariatric surgical procedure for your medical care.

Blue Distinction Centers for Specialty Care (BDCSC) facilities for bariatric surgery may not be available outside California.

5. Transgender Benefit

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits):
$10 Copayment Preferred Provider (Office visits to your Chosen PCP)
$35 Copayment Preferred Provider (Office visits to a Physician who is not your Chosen PCP or for Urgent Care)
60% Non-Preferred Provider

There is a $10 or $35 Copayment for each office visit. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount.

Inpatient Care or Outpatient Care (Facility-Based):
80% Preferred Provider
60% Non-Preferred Provider

Prior authorization must be obtained 3 business days before the start of certain services, not including Outpatient visits. Failure to obtain prior authorization under the terms and conditions specified in this Plan and within the specified time frame may result in denial of payment to your provider.

This Plan provides Benefits for Medically Necessary transgender services. Transgender surgery must be performed at a facility designated and approved by Blue Shield of California for the type of transgender surgery requested and must be prior authorized before being performed. Medical Necessity for transgender surgery will be assessed according to the Standards of Care of the World Professional Association for Transgender Health at http://www.wpath.org/.

Charges for services that are not prior authorized, or which are provided in a facility other than which Blue Shield of California has designated and approved for the transgender surgery requested, will not be considered covered expense.

Travel and lodging expenses may also be covered when necessary to obtain Covered Services and authorized in advance by Blue Shield of California. See Section V. 7. Travel and Lodging Benefits for more information.

As part of your enrollment in the PERS Gold plan, you have access to Included Health. Included Health is a healthcare navigation service available 24/7 in the Included Health mobile app, over the phone, or online at includedhealth.com/calpers. Included Health's integrated Care and Case Management Program can provide advocacy and support along your transgender care journey.

6. Arthroscopy Services

80% Preferred Provider
60% Non-Preferred Provider

Blue Shield of California has a network of Ambulatory Surgery Centers that routinely provide arthroscopy services generally within the maximum Benefit of $6,000. No Benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Included Health and/or visit includedhealth.com/calpers to verify that the facility is listed as a Preferred Ambulatory Surgery Center.

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

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

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

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

7. Cataract Surgery

80% Preferred Provider
60% Non-Preferred Provider

Blue Shield of California has a network of Ambulatory Surgery Centers that routinely provide cataract surgery services generally within the maximum Benefit of $2,000. No Benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please

contact Included Health and/or visit includedhealth.com/calpers to verify that the facility is listed as a Preferred Ambulatory Surgery Center.

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

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

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

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

B. Physician Services (Other Than for Mental Health and Substance Use Disorder Services)

1. Physician Office Visits

$10 Copayment Preferred Provider (Chosen PCP or a Primary Care Physician or an Included Health Virtual PCP)
$35 Copayment Preferred Provider (other than Chosen PCP, Primary Care Physician, or Urgent Care)
60% Non-Preferred Provider

Office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations, medical nutrition therapy, and diabetic counseling. Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person. Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow meter.

2. Allergy Testing and Treatment

80% Preferred Provider
60% Non-Preferred Provider

Office visits for the purpose of allergy testing on and under the skin such as prick/puncture, patch and scratch tests, and treatment, including injectables and serum. This Benefit does not include blood testing for allergies.

3. Inpatient Medical and Surgical Services

80% Preferred Provider
60% Non-Preferred Provider

Physicians' services in a Hospital or Skilled Nursing Facility for examination, diagnosis, treatment, and consultation, including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist,

and radiologist. Inpatient Physician services are covered only when Hospital and Skilled Nursing Facility services are also covered.

4. Treatment of physical complications of a mastectomy, including lymphedemas

80% Preferred Provider
60% Non-Preferred Provider

C. Preventive Health Services

100% Preferred Provider
60% Non-Preferred Provider

Preventive Health Services, as defined, when rendered by a Physician are covered. Services received from Preferred Providers are not subject to the Calendar Year Deductible. However, the Benefit maximum will apply to preventive care for arthroscopy, cataract and colonoscopy services received at an Outpatient Hospital setting. The Member will be responsible for all charges in excess of the Benefit maximum for these services. For services to be covered under the Preventive Health Services Benefit, they must be billed with a preventive code.

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

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law.

1. A Physician's services for routine physical examinations.

2. Immunizations prescribed by the examining Physician.

3. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the Plan.

4. Health screenings as ordered by the examining Physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus, prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis, including screenings for preexposure prophylaxis (PrEP) for prevention of HIV infection.

   Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kits.

   - Must be deemed Medically Necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an In-Network Provider; and

   - Must be a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA waived, FDA cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, HIV, contraception, tobacco use, smoking cessation and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration (HRSA), including the following:

   - All FDA-approved contraceptive Drugs, devices and other products for women, including over-the-counter items, if prescribed by a Physician. This includes contraceptive Drugs, as well as other contraceptive medications such as injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the Drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal. We will not infringe upon a Member's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.

   At least one form of contraception in each of the Drugs, devices and other products identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a Physician, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

   In order to be covered as preventive care, contraceptive Prescription Drugs must be either generic oral contraceptives or brand name Drugs*. Brand name drugs will be covered as Preventive Care Services when Medically Necessary according to your attending Physician, otherwise they will be covered under your Plan's Prescription Drug Benefits. In addition, sterilization procedures and patient education and counseling for all women with reproductive capacity are covered.

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

   - Gestational diabetes screening.

   - Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

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

D. Diagnostic X-ray/Lab Services

100% Quest Diagnostics and Labcorp facilities
80% Preferred Providers and Out-of-Area
60% Non-Preferred Providers

1. X-ray, Laboratory, Major Diagnostic Services. All Outpatient diagnostic x-ray and clinical laboratory tests and services, including diagnostic imaging, electrocardiograms, diagnostic clinical isotope services, bone mass measurements, and periodic blood lipid screening.

2. Genetic Testing and Diagnostic Procedures. Genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Blue Shield of California's medical policy.

See Section F. for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

For services provided by Preferred Providers, the Plan will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services.

For the Quest Diagnostics and Labcorp facility reimbursement, services must be provided at Quest Diagnostics or Labcorp facility.

Please ensure your care is provided at Quest Diagnostics or Labcorp.

To find your nearest Quest Diagnostics location that offers the testing you need, log onto Quest Diagnostics website and accessing Find a Location. Quest Diagnostics website:

questdiagnostics.com

To find your nearest Labcorp location that offers the testing you need, log onto Labcorp website and accessing Find a Lab Near You. Labcorp website:

labcorp.com

If you live within the PERS Gold Basic PPO service area but must travel more than 15 miles from your home or work to the nearest Quest Diagnostics or Labcorp facility, reimbursement for in-network laboratories will be covered at 100%. To receive this level of reimbursement please complete a Laboratory Location Exception form. You can obtain a copy of the Laboratory Location Exception form on Included Health's website at includedhealth.com/calpers.

Blue Shield of California encourages Members to seek services from Preferred Providers to avoid paying extra fees. Some Non-Preferred Providers may charge extra fees that are not covered by Blue Shield of California. Any fees not covered by Blue Shield of California will be the Member's responsibility. See the How to Use this Plan section for information about Preferred and Non-Preferred Providers.

3. Colonoscopy Services

Physician Office Visits

Preventive Care
100% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

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

For purposes of this Benefit, "preventive care" means Physician visits and medical services related to a colonoscopy when billed with a preventive care diagnosis code. For example:
- A routine colonoscopy screening for colon cancer.

Diagnostic Care
80% Preferred Provider and Out-of-Area

60% Non-Preferred Provider

Diagnostic care means Physician visits and medical services related to a colonoscopy when billed with a diagnostic care diagnosis code. For example:
- Follow-up colonoscopy after abnormal results or cancer treatment.

Anesthesia Services
100% Preventive Care, Preferred Provider and Out-of-Area
80% Diagnostic Care, Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Intravenous conscious sedation
There is no Deductible, Copayment, or Coinsurance for Medically Necessary intravenous conscious sedation provided by a Preferred Provider practitioner during a colonoscopy when performed in connection with a preventive colonoscopy; however, the Deductible, Copayment, or Coinsurance for Medically Necessary intravenous conscious sedation will apply for diagnostic care.

Monitored Anesthesia
Prior authorization is required for any anesthesia services provided by an anesthesiologist. Anesthesia that is not authorized as Medically Necessary is not a covered Benefit for preventive or diagnostic care. Your Physician can obtain prior authorization by calling Blue Shield of California; he or she should allow up to five days for the request to be processed. Members should verify prior authorization by calling Included Health at 855-633-4436. If prior authorization has been obtained for diagnostic care, coverage for monitored anesthesia will be subject to the Deductible and Copayment/Coinsurance of the Plan.

Preventive Health Services received from Preferred Providers are not subject to the Calendar Year Deductible. Preventive Health Services received from Non-Preferred Providers are subject to the Calendar Year Deductible; however, it is NOT subject to the Maximum Calendar Year Medical Financial Responsibility limits.

Facility Services

Ambulatory Surgery Centers
100% Preventive Care, Preferred Provider and Out-of-Area
80% Diagnostic Care, Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Preventive Health Services received from Preferred Providers are not subject to the Calendar Year Deductible.

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

Colonoscopy services are considered routine services and can be performed safely at an Ambulatory Surgery Center. If this routine procedure is performed in an Ambulatory Surgery Center, Benefits will be paid according to the Plan.

Blue Shield of California has a network of Ambulatory Surgery Centers that routinely provide arthroscopy services generally within the maximum Benefit of $1,500. No Benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Included Health and/or visit includedhealth.com/calpers to verify that the facility is listed as a Preferred Ambulatory Surgery Center.

Outpatient Hospital
80% Preferred Provider
60% Non-Preferred Provider

Preventive Health Services received from Preferred Providers are not subject to the Calendar Year Deductible; however, the $1,500 Benefit maximum will apply to Preventive Health Services received at an Outpatient Hospital setting. The Member will be responsible for all charges in excess of the Benefit maximum.

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

If this routine service is provided in an Outpatient Hospital setting, whether a preventive or diagnostic service, the Allowable Amount for colonoscopy services is limited **to a maximum of $1,500** per procedure.

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

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

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

E. Durable Medical Equipment, Prostheses and Orthoses and Other Services

80% Preferred Provider
60% Non-Preferred Provider

Medically Necessary Durable Medical Equipment, prostheses and orthoses, and supplies needed to operate Durable Medical Equipment; oxygen and oxygen equipment and its administration; blood glucose monitors (including continuous blood glucose monitor) and all related necessary supplies for the self-management of diabetes, as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; required dialysis equipment and medical supplies; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. When authorized as Durable Medical Equipment, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Blue Shield of California. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standard of practice.

1. Durable Medical Equipment

   a. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item.*

      *This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the Outpatient Prescription Drug Benefit for Benefits for asthma inhalers and inhaler spacers.)

b. Medically Necessary repairs and maintenance of Durable Medical Equipment, as authorized by Blue Shield of California. Repair is covered unless necessitated by misuse or loss.

c. Rental charges for Durable Medical Equipment in excess of the purchase price are not covered.

d. Benefits do not include environmental control equipment or generators. No Benefits are provided for backup or alternate items.

e. Breast pump rental or purchase.
Rental or purchase of one breast pump per pregnancy is covered at no cost to you. For further information call Included Health or go to includedhealth.com/calpers.

See Section S. for devices, equipment and supplies for the management and treatment of diabetes.

If you are enrolled in a Hospice Program through a Preferred Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions are provided by the Hospice Agency. For information see Section N.

2. Prostheses

a. Medically Necessary prostheses, including the following:

1) Supplies necessary for the operation of prostheses;

2) Initial fitting and replacement after the expected life of the item;

3) Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;

4) Prosthetic devices used to restore a method of speaking following laryngectomy, including initial and subsequent Prosthetic devices and installation accessories. This does not include electronic voice producing machines;

5) Cochlear implants;

6) Contact lenses if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia;

7) Artificial limbs and eyes and their fitting;

8) One Medically Necessary scalp hair Prosthesis each Calendar Year, worn for hair loss caused by alopecia areata, alopecia totalis, or alopecia medicamentosa, resulting from the treatment of any form of cancer or leukemia. Benefits are limited to one Prosthetic each year up to a maximum payment of $350 per Member.

b. Benefits do not include self-help/educational devices or any type of speech or language assistance devices, except as specifically provided above. See the Exclusions and Limitations section for a listing of excluded speech and language assistance devices. No Benefits are provided for backup or alternate items.

For surgically implanted and other Prosthetic devices (including Prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Section T. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional Benefit.

3. Orthoses

   a. Medically Necessary orthoses, including the following:

      1) Special footwear required for foot disfigurement which includes but is not limited to foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes or by accident or developmental disability;

      2) Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device, limited to one pair per Calendar Year;

      3) Medically Necessary knee braces for postoperative Rehabilitative Care following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis.

   b. Benefits for Medically Necessary orthoses are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. No Benefits are provided for backup or alternate items.

   c. Benefits are provided for Orthotic devices for maintaining normal activities of daily living only. No Benefits are provided for Orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet.

See Section S. for devices, equipment and supplies for the management and treatment of diabetes.

F. Pregnancy and Maternity Care

The following pregnancy and maternity care is covered subject to the General Exclusions and Limitations.

1. Prenatal and Postnatal Physician Office Visits

   No charge

2. Genetic testing and diagnostic procedures. See Section D. for more information on coverage of other genetic testing and diagnostic procedures.

   100% Quest Diagnostics and Labcorp facilities
   80% Preferred Providers and Out-of-Area
   60% Non-Preferred Provider

3. Inpatient Hospital and Professional Services. Hospital and Professional services for the purposes of a normal delivery, C-section, complications or medical conditions arising from pregnancy or resulting childbirth.

   80% Preferred Provider*

60% Non-Preferred Provider

* Preferred Provider Inpatient Hospital charges (claim submitted by the Hospital only) are covered at 100% if Member is enrolled in the Included Health Maternity Care Program. (Claims must be submitted by the Hospital).

The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed Health Care Provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

Included Health's Maternity Care Program provides help making sense of maternity Benefits, preparing for maternity leave, and accessing prenatal care. Use the Included Health app to search for local Preferred Providers, including OB/GYNs, pediatricians, and specialists. Or, have a Care Coordinator match you with a provider who best meets your needs. You also have access to 24/7 medical advice from a nurse, as well as virtual mental health care and urgent care. Call 855-633-4436 or visit includedhealth.com/calpers for details. Included Health also offers:

- Care and case management
- Education and support
- Help finding maternity classes and lactation support

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

   80% Preferred Provider or Non-Preferred Provider

5. Abortion Services. Abortion is covered for all pregnant persons including, but not limited to, transgender individuals.

   80% Preferred Provider
   60% Non-Preferred Provider

6. Doula Services. Services include health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Support is provided before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doula services can be provided virtually or in person with locations in any setting including, but not limited to homes, office visits, Hospitals, or alternative birth centers.

   This service includes a minimum of 11 visits plus labor and delivery:

   a. Initial visit;
   b. Up to 8 prenatal or postpartum visits,

c. Support during labor and delivery including miscarriage, abortions and stillbirth,
d. Up to 2 extended three-hour postpartum visits.

All visits are limited to one prenatal or postnatal visit per day, per Member. Visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support.

This Benefit does not include belly binding (traditional/ceremonial), birthing ceremonies (i.e. sealing, closing the bones, etc.), group classes on babywearing, massage (maternal or infant), photography, placenta encapsulation, shopping, vaginal steams, or yoga.

In-person doula services are reimbursable up to $1100 per pregnancy. Claims for doula services must be submitted by the Member, not the provider. Call Included Health at 855-633-4436for assistance submitting your claim. Please submit a medical services claim, including Blue Shield of California claim form and the itemized bill from your provider, to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927
Online: includedhealth.com/calpers

7. Breast Feeding Support. Support, counseling and supplies for breast feeding, including rental or purchase of one breast pump per pregnancy, is covered.

100% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

8. Childbirth Classes. Childbirth classes do not apply toward the Maximum Calendar Year Medical Financial Responsibility limits. To prepare new and expectant parents for a birthing experience, Blue Shield of California will pay up to $50 or 50% of total fees (whichever is less) for childbirth classes. Classes will be reimbursed only when given by licensed instructors certified by Lamaze International, Centered Pregnancy/Centering Healthcare Institute, or other nationally-recognized accreditation programs with similar training requirements. Refresher classes are also provided by the Plan up to $25 or 50% of class fees (whichever is less).

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

Pregnancy and maternity care coverage is subject to the General Exclusions and Limitations.

G. Family Planning and Infertility Services

1. Family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; Follow-up services related to contraceptive Drugs, devices, products, and procedures, including but not limited to management of side effects, counseling for continued adherence, and device removal.

80% Preferred Provider
60% Non-Preferred Provider

2. Infertility Services. Diagnosis and treatment of the cause of Infertility, including professional, Hospital, ambulatory surgery center, related services to diagnose and treat the cause of Infertility with the exception of what is excluded in the General Exclusions and Limitations. Treatment of Infertility, except for in-vitro fertilization, ovum transplant, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) procedures. These services are not covered. Your payment for Infertility services will not be applied to the Maximum Calendar Year Coinsurance Responsibility.

   50% Preferred Provider
   50% Non-Preferred Provider

If you're currently receiving or looking for support with family planning, Included Health can help with expert second opinions from Specialists and with help finding and scheduling local in-network care. Contact Included Health to learn more.

For additional information on your family planning related Benefits, use the Included Health app to see your plan info, including Out-of-Pocket Maximum, Copayments, and Coinsurance.

H. Ambulance Services

80% Preferred Provider or Non-Preferred Provider

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

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

Ambulance services are subject to Medical Necessity reviews.

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

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

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

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

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

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

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

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

I. Emergency Services

80% All Providers

There is a $50 Copayment per visit in the Hospital emergency room. If admitted to the Hospital for Outpatient medical observation or on an Inpatient basis, the emergency room Deductible is waived. The $50 payment does not apply to the Calendar Year Deductible or the Maximum Calendar Year Coinsurance Responsibility. However, it does apply to the Calendar Year Out-of-Pocket Maximum.

An emergency means an unexpected medical condition, including a psychiatric Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believe the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health in serious jeopardy (including the health of a pregnant woman or her unborn child), (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part, (4) danger to yourself or to others, (5) inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder. If you receive services in a situation that Blue Shield of California determines did not require Emergency Services, or you did not reasonably believe that an emergency condition existed, you will be responsible for the costs of those services.

For services to be covered under the Emergency Services Benefit, they must be billed with an emergency code. Claims billed without an emergency code will be processed at the lowered the Non-Preferred Benefit. Only Physician charges shall be payable for non-emergency services received in an emergency room of a Hospital. Emergency room facility charges for non-emergency services are not covered. The reimbursement level for Physician or other charges will be based on the Preferred or Non-Preferred status of the provider and Benefits are payable.

1. Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member must notify Included Health by phone within 24 hours of an emergency admission or as soon as medically possible following the admission.

2. Whenever possible, go to the emergency room of your nearest Preferred Hospital for medical emergencies. A listing of Preferred Hospitals is available in your PPO Physician and Hospital Directory.

3. Continuing or Follow-up Treatment. If you receive Emergency Services from a Hospital which is a Non-Preferred Hospital, follow-up care must be authorized by Blue Shield of California or it may not be covered. If, once your Emergency Medical Condition is stabilized, and your treating Health Care Provider at the Non-Preferred Hospital believes that you require additional Medically Necessary Hospital services, the Non-Preferred Hospital must contact Blue Shield of California to obtain timely authorization. The Plan may authorize continued Medically Necessary Hospital services by the Non-Preferred Hospital. If Blue Shield of California determines that you may be safely transferred to a Hospital that is contracted with the Plan and you refuse to consent to the transfer, the Non-Preferred Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the Non-Preferred Hospital is unable to determine the contact information for PERS Gold in order to request prior authorization, the Non-Preferred Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a Non-Preferred Hospital, you should contact Included Health at the telephone number on your identification card.

4. Claims for Emergency Services. Contact Included Health to obtain a claim form.

   Emergency. If Emergency Services were received and expenses were incurred by the Member, for services other than medical transportation, the Member must submit a complete claim with the emergency service record for payment to the Plan, within 1 year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that these services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered, it will notify the Participant of that determination. The Plan will notify the Participant of its determination within 30 days from receipt of the claim. In the event covered medical transportation services are obtained in such an emergency situation, PERS Gold shall pay the medical transportation provider directly.

J. Urgent Care Services

1. Urgent Care Centers

   $35 Copayment Physician office visit
   60% Non-Preferred Provider

   Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health. Urgent Care does not require the use of a Hospital or emergency room. Some urgent care facilities are affiliated with a Hospital or Hospital group and you may incur a separate Facility charge. Charges for Facility/Hospital based services are not covered under this Urgent Care Benefit. Please refer to the Hospital Benefit for details regarding Facility/Hospital based urgent care centers. Choosing to visit a Hospital or an urgent care affiliated with a Hospital or Hospital group for Urgent Care services may result in increased Copayment or Coinsurance responsibility and/or denial of Benefits.

Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount.

See the Out-of-area services section for information on urgent care services outside California.

2. Virtual Urgent Care

$10 Copayment Included Health Virtual Provider
60%Non-Preferred Provider

Through Included Health, you have access to virtual urgent care, available 24/7 for medical conditions that are not life-threatening, but prompt care is needed to prevent serious deterioration of your health.

To use Included Health virtual urgent care:

a. Download the Included Health app.
b. Activate your account if you haven't done so yet.
c. On the home screen, select *Virtual Care.*
d. Select *Urgent care.*
e. Follow the page-by-page instructions.
f. Once you've completed the intake instructions, you will be connected with the next available provider.

K. Home Health Care Services and Home Infusion Therapy

80% Preferred Provider
60% Non-Preferred Provider

1. Home Health Care Services

Benefits are provided for home health care services when the services are Medically Necessary, ordered by the Personal Physician and authorized. Up to 45 visits per Calendar Year are covered.

a. Home visits to provide skilled nursing services* and other skilled services by any of the following professional providers are covered:

1) Registered nurse;

2) Licensed vocational nurse;

3) Certified home health aide in conjunction with the services of 1) or 2), above;

4) Medical Social Worker.

5) Physical therapist, occupational therapist, or speech therapist.

Speech, Physical, and Occupational Therapies provided in the home are covered under the Outpatient or Out-of-Hospital Therapies Benefit and subject to the limitations specified in the Benefit description.

b. In conjunction with the professional services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan, to the extent the Benefit would have been provided had the Member remained in the Hospital or Skilled Nursing Facility, except as excluded in the General Exclusions and Limitations.

This Benefit does not include medications, drugs, or injectables covered under the Outpatient Prescription Drug Benefit.

See Section N. for information about when a Member is admitted into a Hospice Program and a specialized description of skilled nursing services for Hospice care.

For information concerning diabetes self-management training, see Section S.

2. Home Infusion/Home Injectable Therapy Provided by a Home Infusion Agency

   Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency. Note: For services related to hemophilia, see item 4. below.

   Services include home infusion agency skilled nursing services, administration of parenteral nutrition formulations, administration of enteral nutrition formulas, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory services and for Medically Necessary, FDA approved injectable medications, when prescribed by the Physician and prior authorized, and when provided by a home infusion agency.

   This Benefit does not include medications, drugs, insulin, insulin syringes, and services related to hemophilia which are covered as described below.

*Skilled nursing services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

3. Hemophilia Home Infusion Products and Services

   Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by the Plan and must be provided by a participating Hemophilia Infusion Provider. (Note: Most Preferred Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) A list of Preferred Hemophilia Infusion Provider is available online at includedhealth.com/calpers. You may also verify this information by calling Included Health at 855-633-4436.

   Hemophilia infusion providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

   Following evaluation by your Physician, a prescription for a blood factor product must be submitted to and approved by the Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in Section I.)

   Included in this Benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a participating Hemophilia Infusion Provider, and Medically Necessary services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other medical Benefits described elsewhere in this Benefit Descriptions section.

   This Benefit does not include:

a. Physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;

b. Services from a hemophilia treatment center or any provider not prior authorized by the Plan; or,

c. Self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services and certain drugs may be covered under the Outpatient Prescription Drug Benefit or as described elsewhere in this Benefit Descriptions section.

L. Outpatient or Out-of-Hospital Therapies

Outpatient or Out-of-Hospital Therapies include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient Department of a Hospital. Benefits for Speech Therapy are also described below. Physical and Occupational Therapy are subject to a maximum of 24 visits per Calendar Year and no more than one visit per day. Medically Necessary services will be authorized for an initial treatment period and any additional subsequent Medically Necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is Medically Necessary.

1. Physical Therapy

   80% Preferred Provider and Out-of-Area
   60% Non-Preferred Provider

2. Occupational Therapy

   80% All Providers (Occupational Therapy)

3. Cardiac rehabilitation

   80% Preferred Provider
   60% Non-Preferred Provider

   Outpatient cardiac rehabilitation is primarily a monitored exercise treatment program design to strengthen the heart muscle, increase cardiac efficiency, or decrease the frequency of arrhythmia or angina. The cardiac rehabilitation program is designed to help cardiac patients change their overall lifestyle so that health risks are decreased. Outpatient cardiac rehabilitation is eligible for Benefits only when prescribed by a Physician for the prevention or treatment of heart disease. Upon referral of a Physician, Medically Necessary services are covered to a maximum of 40 visits per Calendar Year when provided by licensed personnel in a formal cardiac rehabilitation program. Outpatient cardiac rehabilitation services do not include cardiac care services or any services in connection with a heart transplant. Professional and facility claims for the same date of service will be treated as one visit.

4. Pulmonary rehabilitation

   80% Preferred Provider
   60% Non-Preferred Provider

Pulmonary rehabilitation is covered upon referral of a Physician. Medically Necessary services are covered to a maximum of 30 visits per Calendar Year when provided by licensed personnel in a formal pulmonary rehabilitation program. Professional and facility claims for the same date of service will be treated as one visit.

See Section K. for information on coverage for Rehabilitative Care rendered in the home.

5. Speech Therapy

80% Preferred Provider
60% Non-Preferred Provider

Outpatient Benefits for Medically Necessary Speech Therapy services when diagnosed and ordered by a Physician and provided by an appropriately licensed speech therapist/pathologist, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development. and when rendered in the provider's office or Outpatient Department of a Hospital.

Subject to a maximum of 24 visits per Calendar Year. Continued Outpatient Benefits will be provided for Medically Necessary services as long as continued treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records may be reviewed periodically. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Member will be notified of this determination and Benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under Section K., no Outpatient Benefits are provided for Speech Therapy, speech correction, or speech pathology services.

See Section K. for information on coverage for Speech Therapy services rendered in the home. See Section A. for information on Inpatient Benefits and Section N. for Hospice Program services.

M. Skilled Nursing Facility Services

80% Preferred Provider
60% Non-Preferred Provider

Subject to all of the Inpatient Hospital services provisions under Section A., Medically Necessary skilled nursing services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. This Benefit is limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Preferred Hospice Agency. Custodial Care is not covered.

For information concerning "Hospice Program Services" see Section N.

N. Hospice Program Services

80% Preferred Provider or Non-Preferred Provider

Benefits are provided for the following services through a Preferred Hospice Agency when an eligible Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a terminal illness as determined by his Physician's certification and the admission must receive

prior approval from Blue Shield of California. (Note: Members with a terminal illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Preferred Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Members can continue to receive Covered Services that are not related to the palliation and management of the terminal illness from the appropriate provider.

Note: Hospice services provided by a Non-Preferred Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Preferred Hospice Agencies and only when prior authorized by Blue Shield of California.

All of the services listed below must be received through the Preferred Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).

2. Interdisciplinary Team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.

3. Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse.

4. Bereavement services.

5. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

6. Medical direction with the medical director being also responsible for meeting the general medical needs for the terminal illness of the Members to the extent that these needs are not met by the Member's other providers.

7. Volunteer services.

8. Short-term Inpatient care arrangements.

9. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions.

10. Physical Therapy, Occupational Therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Continuous Nursing Services (Private Duty Nursing) are covered for as much as 24 hours a day during periods of crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either homemaker services or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but the care provided during these periods must be predominantly nursing care.

12. Respite care services are limited to an occasional basis and to no more than 5 consecutive days at a time.

Members are allowed to change their Preferred Hospice Agency only once during each period of care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another period of care if the Preferred Provider recertifies that the Member is terminally ill.

Definitions

Bereavement Services - services available to the immediate surviving family members for a period of at least 1 year after the death of the Member. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

Continuous Home Care - home care provided during a period of crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker services or home health aide services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care.

Home Health Aide Services - services providing for the personal care of the terminally ill Member and the performance of related tasks in the Member's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home health aide services shall be provided by a person who is certified by the California Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services - services that assist in the maintenance of a safe and healthy environment and services to enable the Member to carry out the treatment plan.

Hospice Service or Hospice Program - a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary caregiver and the family of the Hospice patient, and which meets all of the following criteria:

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.

2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and his family.

3. Requires the Interdisciplinary Team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term Inpatient services. Short-term Inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

5. Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death.

6. Actively utilizes volunteers in the delivery of Hospice services.

7. Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

Interdisciplinary Team - the Hospice care team that includes, but is not limited to, the Member and his family, a Physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction - services provided by a licensed Physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Member's Preferred Provider, as requested, with regard to pain and symptom management, and liaison with Physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "medical director".

Period of Care - the time when the Preferred Provider recertifies that the Member still needs and remains eligible for Hospice care even if the Member lives longer than 1 year. A period of care starts the day the Member begins to receive Hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis - a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care - a written plan developed by the attending Physician and surgeon, the "medical director" (as defined under "Medical Direction") or Physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Member and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered.

Respite Care Services - short-term Inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member.

Skilled Nursing Services - nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the Interdisciplinary Team and the Member's provider to a Member and his family that pertain to the palliative, supportive services required by a Member with a terminal illness. Skilled nursing services include, but are not limited to, Member assessment, evaluation and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled nursing services provide for the continuity of services for the Member and his family and are available on a 24-hour on-call basis.

Social Service/Counseling Services - those counseling and spiritual services that assist the Member and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Terminal Disease or Terminal Illness - a medical condition resulting in a prognosis of life of 1 year or less, if the disease follows its natural course.

Volunteer Services - services provided by trained Hospice volunteers who have agreed to provide service under the direction of a Hospice staff member who has been designated by the Hospice to provide direction to Hospice volunteers. Hospice volunteers may provide support and companionship to the Member and his family during the remaining days of the Member's life and to the surviving family following the Member's death.

O. Inpatient Mental Health and Substance Use Disorder Services

80% Preferred Provider
60% Non-Preferred Provider

All non-emergency Mental Health and Substance Use Disorder services, including Residential Care, must be prior authorized. For prior authorization for Mental Health and Substance Use Disorder services, Members should contact Included Health.

Benefits are provided for the following Medically Necessary covered Mental Health and Substance Use Disorders, subject to applicable Copayments and charges in excess of any Benefit maximums. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the Benefit description below, and to the Exclusions and Limitations set forth in this booklet.

Benefits are provided for Inpatient Hospital and professional services in connection with hospitalization for the treatment of Mental Health and Substance Use Disorders.

Benefits are provided for Inpatient and professional services in connection with Residential care admission for the treatment of Mental Health and Substance Use Disorders. All non-emergency Mental Health and Substance Use Disorder services must be prior authorized . In addition, when no Preferred Provider is available to perform the needed service, Blue Shield of California will refer you to a Non-Preferred provider and authorize services to be received.

See Section A. for information on Medically Necessary Inpatient substance use disorder detoxification.

P. Outpatient Mental Health and Substance Use Disorder Services

1. Benefits are provided for Physician Outpatient office visits, Physician Outpatient Hospital visits, and Physician Urgent Care visits for Mental Health and Substance Use Disorders. Includes:
   - Individual and group sessions
   - Physician/psychiatrist visits for mental health Medication management
   - Physician/psychiatrist Outpatient consultations.

   $10 Copayment Preferred Provider
   60% Non-Preferred Provider

   Benefits are provided for Hospital and Physician services Medically Necessary for short-term medical management of detoxification or withdrawal symptoms. There is a $10 Copayment applies for each office visit to a Preferred Provider Physician. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount.

The $10 Copayment applies to non-emergency Physician services received in the emergency room of a Hospital. This Copayment is only for the Physician visit.

For Benefits to be payable, the provider must be a currently licensed Physician or mental Health Professional.

When available in your area, Benefits are also available for Intensive In-Home Behavioral Health Programs.

Coverage is provided for Medically Necessary Mental Health and Substance Use Disorder Services. Custodial Care and educational programs are not covered.

2. All covered Outpatient Facility-based non-overnight care provided by a Residential Treatment Facility, Intensive Outpatient Program, or Day/Partial Hospitalization Program must be prior authorized at least 3 business days before services are provided. Failure to obtain prior authorization under the terms and conditions specified in this Plan and within the specified time frame may result in denial of payment to your provider.

   80% Preferred Provider
   60% Non-Preferred Provider

   For Benefits to be payable, the provider must be a currently licensed Physician or mental Health Professional.

   Coverage is provided for Medically Necessary facility-based treatment through non-overnight stays (such as Intensive Outpatient Programs and Day/Partial Hospitalizations). Custodial Care and educational programs are not covered.

3. Autism Spectrum Disorder

   $10 Copayment, Preferred Provider office visit
   60% Non-Preferred Provider

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

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

   - The treatment must be prescribed by a licensed Physician (an M.D. or D.O.) or developed by a licensed clinical psychologist,
   - The prescribed treatment plan must be provided by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider, and

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

4. Virtual Mental Health Services

$10 Copayment, Preferred Provider and Included Health Virtual Provider
60% Non-Preferred Provider

This Plan includes access to virtual therapy and psychiatry care through your Blue Shield of California Provider Network and Included Health. To use Included Health virtual urgent care:

a. Download the Included Health app.
b. Activate your account if you haven't done so yet.
c. On the home screen, select *Virtual Care.*
d. Select *Mental health.*
e. Follow the page-by-page instructions.
f. Once you've completed the intake instructions, make a selection from the list of available providers.
g. Select an appointment based on the provider's availability. You will be reminded when it is time for your appointment.

Q. Special Transplant Benefits

80% at Blue Distinction Centers for Specialty Care (BDCSC)

Benefits are provided for certain procedures listed below only if: (1) performed at a Transplant Network Facility approved by Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from Blue Shield of California's Corporate Medical Director, and (3) the recipient of the transplant is a Member.

Blue Shield of California's Corporate Medical Director shall review all requests for prior authorization and shall approve or deny Benefits, based on the medical circumstances of the patient, and in accordance with established PERS Gold medical policy. Failure to obtain prior written authorization as described

above and/or failure to have the procedure performed at a Plan approved Transplant Network Facility will result in denial of claims for this Benefit.

Pre-transplant evaluation and diagnostic tests, transplantation and follow-ups will be allowed only at a Plan approved Transplant Network Facility. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than a Plan approved Transplant Network Facility will not be approved. Evaluation of potential candidates at a Blue Shield of California Transplant Network Facility is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or more than one Transplant Network Facility will not be authorized unless the Medical Necessity of repeating the service is documented and approved. For information on the PERS Gold approved Transplant Network, call Included Health at 855-633-4436.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;
2. Human lung transplants;
3. Human heart and lung transplants in combination;
4. Human liver transplants;
5. Human pancreas transplants;
6. Human kidney and pancreas transplants in combination (kidney only transplants are covered under Section R.);
7. Human bone marrow transplants, peripheral stem cell transplantation, or umbilical cord transplants;
8. Human small bowel transplants;
9. Human small bowel and liver transplants in combination.

Reasonable charges for services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

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

Travel and lodging expenses may also be covered when necessary to obtain Covered Services and authorized in advance by Blue Shield of California. See Section V. 7. Travel and Lodging Benefits for more information.

R. Organ Transplant Benefits

80% Preferred Provider
60% Non-Preferred Provider

Hospital and professional services provided in connection with human organ transplants are a Benefit to the extent that they are provided in connection with the transplant of a cornea, kidney, or skin, and the recipient of such transplant is a Member.

Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered.

S. Diabetes Care

1. Diabetic Equipment

80% Preferred Provider
60% Non-Preferred Provider

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary and authorized:

a. blood glucose monitors, including continuous blood glucose monitors and those designed to assist the visually impaired and all related necessary supplies;

b. insulin pumps and all related necessary supplies;

c. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of insulin;

e. diabetic testing supplies including blood and urine testing strips and test tablets, generic glucose (blood) test strips and lancets and lancet puncture devices and pen delivery systems for the administration of insulin.

2. Diabetes Self-Management Training and Medical Nutrition Therapy

$10 Copayment Preferred Provider (office visits to your Chosen PCP)
$35 Copayment, Preferred Provider (office visits to a Physician who is not your Chosen PCP)
60% Non-Preferred Provider

Diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the diabetes-related devices and equipment and any additional treatment for these services if directed or prescribed by the Member's Physician and authorized. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

T. Reconstructive Surgery

80% Preferred Provider
60% Non-Preferred Provider

Medically Necessary services in connection with Reconstructive Surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance (including congenital anomalies) are covered. In accordance with the Women's Health & Cancer Rights Act, surgically implanted and other Prosthetic devices (including Prosthetic bras) and Reconstructive Surgery on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas, are covered. Surgery must be authorized as described herein. Benefits will be provided in

accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No Benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

1. Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
2. Surgery to reform or reshape skin or bone;
3. Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
4. Hair transplantation;
5. Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology;
6. Dental surgery, including dental implants (materials implanted into or on bone or soft tissue), is not covered even if related to Emergency Services or treatment of injury, except as specifically provided under Section Q.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

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

U. Clinical Trials for Treatment of Cancer or Life-Threatening Diseases or Conditions

Physician Services and Hospital Services Copayment or Coinsurance applies.

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a Life-Threatening Disease or Condition when prior authorized through the Member's Physician, and:

1. The clinical trial has a therapeutic intent and the Personal Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
2. The Hospital and/or Physician conducting the clinical trial is a Preferred Provider, unless the protocol for the trial is not available through a Preferred Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.

"Routine patient care" consists of those services that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial, but does not include:

1. The investigational item, device, or service, itself;
2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;

5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other Life-Threatening Disease or Condition, and is limited to a trial that is:

1. Federally funded and approved by one of the following:

   a. one of the National Institutes of Health;

   b. the Centers for Disease Control and Prevention;

   c. the Agency for Health Care Research and Quality;

   d. the Centers for Medicare & Medicaid Services;

   e. a cooperative group or center of any of the entities in a to d, above; or the Federal Departments of Defense or Veterans Administration;

   f. qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

   g. the Federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

"Life-Threatening Disease or Condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

V. Additional Services

1. Medications Administered by a Healthcare Professional

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

2. Hearing Aid Services

80% Preferred Provider
60% Non-Preferred Provider.
Evaluation is in addition to the $1,000 maximum allowed every 36 months for both ears for the hearing aid and ancillary equipment.

a. Audiological Evaluation. To measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

b. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid. For Members up to 26 years of age, hearing aids are covered at 100% up to the Allowable Amount for both ears every 36 months to prevent or treat speech and language development delay due to hearing loss.

Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months. Also excludes surgically implanted hearing devices. Cochlear implants are not considered surgically implanted hearing devices and are covered as a Prosthetic under Section E.

Limitations: Maximum payment will not exceed $1,000 per Member for both ears for the hearing aid instrument, and ancillary equipment.

3. Smoking Cessation

This Plan covers without cost-sharing: 1. Screening for tobacco use; and, 2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

- Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
- All Food and Drug Administration (FDA)-approved tobacco cessation Medications (including both Prescription and over-the-counter Medications) for a 90-day treatment regimen when prescribed by a Health Care Provider without prior authorization.

Members who participate and complete a smoking cessation class or program will be reimbursed up to $100 per class or program per Calendar Year. Members may contact their local Hospital for information about these classes and programs. If you have a question about the smoking cessation Benefit, you should call Included Health at 855-633-4436.

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

4. Acupuncture Benefits

$15 Copayment Preferred Provider
60% Non-Preferred Provider

Covered up to a combined Benefit maximum of 20 visits with Chiropractic Care Covered Services.

Benefits are provided for routine acupuncture Services up to the maximum visits per Calendar Year as shown above.

5. Chiropractic Care

$15 Copayment Preferred Provider
60% Non-Preferred Provider

Covered up to a combined Benefit maximum of 20 visits with Acupuncture Benefits Covered Services.

Manipulation of the spine to correct a subluxation. Benefits are provided up to the maximum visits per Calendar Year as shown above.

6. Christian Science Treatment

80% Preferred Provider or Non-Preferred Provider.

Outpatient treatment for a covered illness or injury through prayer is payable when services are provided by a Christian Science Nurse, Christian Science Nursing Facility, or Christian Science Practitioner. This Benefit includes treatment in absentia (Christian Science Practitioners or nurses providing services, such as consultation or prayer, via the telephone).

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

7. Travel and Lodging Benefits

The Plan will cover travel and lodging for eligible Medically Necessary services including, but not limited to, the services listed below that cannot be accessed within 50 miles from the Member's permanent residence up to $5,000 per occurrence. This includes transportation, lodging, and meals for the Member and a companion (both parents/guardians when patient is under 18).

- Abortion services
- Bariatric surgery
- Organ and tissue transplants
- Gender-affirming care
- Acute Inpatient pediatric care (except direct admission to the neonatal intensive care unit) or specialty Inpatient pediatric care (except direct admission to the pediatric intensive care unit)
- Outpatient pediatric hematology and oncology, including preoperative and postoperative visits

Travel expenses must be prior authorized. For travel expense reimbursement, you must submit receipts, claim forms, and any other documentation required by the plan. You must also have a claim or proof of claim for the eligible Covered Service for which you traveled on file with the plan prior to reimbursement. Claim forms are available online at includedhealth.com/calpers. Included Health can help you submit your claim to Blue Shield of California.

Please send claims documentation to:
Blue Shield of California
P.O. Box 272540
Chico, CA 95927

No Benefits are payable for unauthorized travel expenses.

The Calendar Year Deductible will not apply, and no Copayments or Coinsurance will be required for authorized travel expenses. Expenses must be reasonably necessary. Reimbursable expenses include, if appropriate:

- Transportation to and from the facility to receive eligible Covered Services;
- Hotel accommodations if one or more overnight stays are required to obtain eligible Covered Services. Limited to 1 double occupancy room up to $200/day. Only the room is covered. All other hotel expenses are excluded;
- Meals. Limited to $100/day. Expenses for tobacco, alcohol, drugs, phone, television, and recreation are excluded;
- Companion expenses for reimbursable expenses as listed above; and
- Both parents' or guardians' expenses for reimbursable expenses as listed above if the Member is under age 18.

For more details, refer to the Travel and Lodging Benefit description online at includedhealth.com/calpers or call Included Health at 855-633-4436.

Certain travel expense reimbursements may be tax reportable. When required, we will issue a Form 1099-MISC to you, reporting travel expense reimbursements. We do not provide tax advice. If you have tax questions about travel expense reimbursements, consult with your tax advisor.

Exclusions and Limitations

General Exclusions and Limitations

Unless exceptions to the following exclusions are specifically made elsewhere in the Plan, no Benefits are provided for services which are:

1. **Aids and Environmental Enhancements**

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

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

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

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

4. **Childbirth Classes**. Childbirth classes will be reimbursed only when given by licensed instructors certified by Lamaze International, Centered Pregnancy/Centering Healthcare Institute, or other nationally recognized accreditation programs with similar training requirements, see the Pregnancy and Maternity Care Benefit. Classes devoted solely to individual perinatal specialties, other than Lamaze, are not covered.

5. **Clinical Trials.** Services and supplies in connection with clinical trials are not covered except as specifically provided in the Clinical Trials Benefit.

6. **Close-Relative Services.** Services performed by a close relative or by a person who ordinarily resides in the Member's home.

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

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

9. **Custodial or Domiciliary Care.**

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

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

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

d. Services provided by a Skilled Nursing Facility, unless specifically stated under the Skilled Nursing and Outpatient or Out-of-Hospital Therapies Benefit.

10. **Dental Care, Dental Appliances.** For dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under Q.; for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic, and other services such as dental cleaning, tooth whitening, x-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under A. and R.

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

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

13. **Excess Charges**. Any expense incurred for Covered Services in excess of Plan Benefits or maximums.

14. **Experimental or Investigational 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 Blue Shield of California Medical Policy to be Experimental and Investigational in Nature are not covered.

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

16. **Feet, Procedures Affecting.** For routine foot care and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming (except as may be provided through a Hospice Agency); treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot; special footwear (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically provided under E. andS

17. **Fraud, Waste, Abuse, and Other Inappropriate Billing.** Services from a Non-Preferred Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes a Non-Preferred Provider's failure to submit medical records required to determine the appropriateness of a claim.

18. **Genetic Testing.** For genetic testing except as described under D. and F.

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

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

21. **Hearing Conditions**

    a. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
    b. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.
    c. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.
    d. Replacement of a hearing aid more than once in any period of 36 months.
    e. Surgically implanted hearing devices except when Medically Necessary in accordance with Blue Shield of California's Medical Policy as specifically provided in the Durable Medical Equipment Benefit.

22. **Home Monitoring Equipment.** For home testing devices and monitoring equipment, except for COVID-19 at-home testing kits, sexually transmitted disease home testing kits or as specifically provided under E.

23. **Hospital care programs.** Hospital care programs or services provided in a home setting (Hospital-at-home programs).

24. **Infertility Reversal.** For or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for Medically Necessary treatment of medical complications.

25. **Infertility Services.** For any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, ovum transplants, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic Sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, and sperm (except for artificial insemination), services or medications to treat low sperm count or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield of California health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.

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

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

28. **Mobile/Wearable Devices.** Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

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

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

31. **Organ Transplants.** Incident to an organ transplant, except as provided under Q. and R.

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

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

34. **Private Duty Nursing (Continuous Nursing Services).**
    a. Private-duty skilled nursing, unless provided under the Home Health Care or Hospice Care Benefits.
    b. Private-duty unskilled nursing.

35. Psychiatric or Psychological Care
    a. Treatment of the following conditions is excluded under this Plan:
        1. sexual disorders, except as provided in the Transgender Surgery Benefit;

2. abuse of Drugs, except as provided in the Substance Use Disorder Benefit;
3. development disorders, except as provided in the Autism Spectrum Disorder Benefit; and
4. abnormal behavior which is not directly attributed to a mental disorder.

b. Services on court order or as a condition of parole or probation unless the services are otherwise covered by the Plan.
c. Marriage and family counseling for the sole purpose of resolving conflicts between a Subscriber and his or her spouse, or domestic partner or children.
d. Non-therapeutic treatment, Custodial Care and educational programs.

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

36. Rehabilitation or Rehabilitative Care
a. Inpatient charges in connection with a Hospital stay primarily for environmental change, or treatment of chronic pain unless provided under the Hospice Benefit.
b. Outpatient charges in connection with conditioning exercise programs (formal or informal).
c. Any testing, training or Rehabilitation for educational, developmental or vocational purposes, except as specifically provided under the Autism Spectrum Disorder Benefit.

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

38. Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Facility.

This exclusion includes procedures, equipment, services, supplies or charges for the following but not limited to:

- Domiciliary Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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

40. Speech Therapy. No Benefits are provided for:
a. the correction of stammering, stuttering, lisping, tongue thrust;

b. functional maintenance using routine, repetitious, and/or reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors);
c. procedures that may be carried out effectively by the patient, family, or caregivers (e.g., maintenance therapy);
d. Inpatient charges in connection with a Hospital Stay solely for the purpose of receiving Speech Therapy.

Outpatient Speech Therapy, speech correction or speech pathology services are not covered except as provided in the Speech Therapy Benefit or provided in the Autism Spectrum Disorder Benefit.

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

42. **Telephone, Facsimile Machine, and E-mail Consultations**. Telephone, facsimile machine, and electronic mail consultations for any purpose, whether between the Physician or other Health Care Provider and the Plan Member or Plan Member's family, or involving only Physicians or other Health Care Providers.

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

44. **Transportation and Travel Expense.** Expense incurred for transportation, except as specifically provided in the Ambulance Benefit, and the Travel and Lodging Benefit. Mileage reimbursement except as specifically provided in the Travel and Lodging Benefit and approved by Blue Shield of California. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

45. **Treatment Plan**. A written or oral treatment plan submitted or given for the purpose of claim or Medical Necessity review. Services or a plan of treatment prior authorized by the Plan during a Contract Period must be commenced during the same Contract Period. To qualify for continuing treatment in a subsequent Contract Period, the services or plan of treatment must be reauthorized. Otherwise, only the Benefits in effect during a Contract Period are available or covered.

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

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

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

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

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

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

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

48. **Weight control programs and exercise programs.** Any program, supply, or surgery for dietary control, weight control, or complications arising from weight control, or obesity, whether or not prescribed or recommended by a Physician, including, but not limited to:

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

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

This exclusion will not apply to Medically Necessary surgical treatment of adult morbid obesity as specifically provided in the Bariatric Surgery Benefit, and to Medically Necessary medication treatment of obesity for adults and adolescents as outlined in the Outpatient Prescription Drug Benefit Program administered by Optum Rx®.

49. **Wilderness programs.** Wilderness or other outdoor camps and/or programs.

50. **Workers' Compensation/Work-Related Injury.** For or 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 Blue Shield of California provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of Benefits provided by Blue Shield of California for the treatment of the injury or disease as reflected by the providers' usual billed charges.

See the Medical Claims Review and Appeals Process section for information on filing a Grievance or Appeal, and your rights to independent medical review.

Medical Necessity Exclusion

All services must be Medically Necessary. The fact that a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. PERS Gold may limit or exclude Benefits for services which are not Medically Necessary.

To confirm a procedure is Medically Necessary, contact Included Health at 855-633-4436 or use the Included Health mobile app.

Limitations for Duplicate Coverage

In the event that you are covered under the Plan and are also entitled to Benefits under any of the conditions listed below, Blue Shield of California's liability for services (including room and board) provided to the Member for the treatment of any one illness or injury shall be reduced by the amount of Benefits paid, or the reasonable value or the amount of Blue Shield of California's fee-for-service payment to the provider, whichever is less, of the services provided without any cost to you, because of your entitlement to such other Benefits. This exclusion is applicable to Benefits received from any of the following sources:

Exclusions and Limitations

1. Benefits provided under Title 18 of the Social Security Act ("Medicare"). If a Member receives services to which the Member is entitled under Medicare and those services are also covered under this Plan, the Preferred Provider may recover the amount paid for the services under Medicare. This provision does not apply to Medicare Part D (outpatient prescription drug) benefits. This limitation for Medicare does not apply when the employer is subject to the Medicare Secondary Payor Laws and the employer maintains:

   a. an employer group health plan that covers

      1) persons entitled to Medicare solely because of end-stage renal disease, and

      2) active employees or spouses or domestic partners entitled to Medicare by reason of age, and/or

   b. a large group health plan as defined under the Medicare Secondary Payor laws that covers persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to a Member who becomes eligible for Medicare on the date that the Member received notice of his eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision, except that this exclusion does not apply to Medi-Cal; or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the reasonable costs of services provided to the person at a Veterans Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.

Exception for Other Coverage

Preferred Providers may seek reimbursement from other third party payors for the balance of their reasonable charges for services rendered under this Plan.

Claims and Services Review

Blue Shield of California reserves the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield of California may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

General Provisions

Members Rights and Responsibilities

You, as a PERS Gold Basic PPO Plan Member, have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity;

2. Receive information about all health services available to you, including a clear explanation of how to obtain them;

3. Receive information about your rights and responsibilities;

4. Receive information about your PPO Health Plan, the services we offer you, the Physicians and other practitioners available to care for you;

5. Have reasonable access to appropriate medical services;

6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment;

7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage;

8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or Benefit coverage, so you can make an informed decision before you receive treatment;

9. Receive Preventive Health Services;

10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living;

11. Have confidential health records, except when disclosure is required or permitted by state law (California) or federal law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician;

12. Communicate with and receive information from Included Health and Blue Shield of California in a language you can understand;

13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available;

14. Be fully informed about Blue Shield of California's Grievance procedure and understand how to use it without fear of interruption of health care;

15. Voice complaints or Grievances about the PPO Health Plan or the care provided to you;

16. Make recommendations regarding Blue Shield of California's Member rights and responsibilities policy.

You, as a PERS Gold Basic PPO Plan Member, have the responsibility to:

General Provisions

1. Carefully read all PPO materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your PPO membership as explained in the Benefit Booklet;

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed;

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you;

4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.

5. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;

6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given;

7. Make and keep medical appointments and inform your Physician ahead of time when you must cancel;

8. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation;

9. Offer suggestions to improve the PPO Plan;

10. Help Blue Shield of California to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;

11. Notify Blue Shield of California as soon as possible if you are billed inappropriately or if you have any complaints;

12. Treat all Plan personnel respectfully and courteously as partners in good health care;

13. Pay your dues, Copayments and charges for non-covered services on time;

14. For all Mental Health and Substance Use Disorder services, follow the treatment plans and instructions and obtain prior authorization for all non-emergency Inpatient Mental Health and Substance Use Disorder services.

Confidentiality of Medical Records and Personal Health Information

Blue Shield of California and Included Health protects the confidentiality/privacy of your personal health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Your information will not be disclosed without your authorization, except as permitted by federal law.

A STATEMENT DESCRIBING THE POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. The policies and procedures regarding our confidentiality/privacy practices

are contained in the "Notice of Privacy Practices," which you may obtain either by calling Included Health at 855-633-4436, or by accessing includedhealth.com/calpers and printing a copy.

If you are concerned that Blue Shield of California or Included Health may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California or Included Health may need information from medical providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Plan. You agree that any provider or entity can disclose to Blue Shield of California or Included Health that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California or Included Health in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the information in your possession. Failure to assist Blue Shield of California or Included Health in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield of California or Included Health will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Payment of Benefits – Assignment of Benefits

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

Payment of Benefits. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. The Benefits of this booklet will be paid directly to Preferred Providers (e.g., and medical transportation providers). Hospitals, Physicians and other Health Care Providers of service or the person or persons having paid for your Hospital or medical services will be paid directly when you assign Benefits in writing no later than the time of submitting a claim. These payments fulfill the Plan's obligation to you for those services.

Non-Preferred Providers will be paid directly when Emergency Medical Condition services and care are provided to you or one of your Dependents. The Plan will continue such direct payment until the emergency care results in stabilization.

If you or one of your Dependents receives Covered Services other than emergency care from a Non-Preferred Provider, payment may be made directly to the Member and you will be responsible for payment to that provider. An assignment of Benefits to a Non-Preferred Provider, even if assignment includes the provider's right to receive payment, is generally void. However, there are certain situations in which an assignment of Benefits is permitted. For example, if you receive services from a Preferred Provider facility at which, or as a result of which, you receive non-emergency services from a Non-Preferred Provider such as a radiologist, anesthesiologist or pathologist, an assignment of Benefits to such Non-Preferred Provider will be permitted. Any payments for the assigned Benefits fulfill our obligation to you for those services.

Assignment. You authorize Blue Shield of California, in its own discretion and on behalf of the Employer, to make payments directly to providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the Plan. Blue Shield of California also reserves the right, in its own discretion, to make payments directly to you as opposed to any provider for a Covered Service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Non-Preferred Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan (whether to any provider for a Covered Service or you) will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by applicable Federal law. Once a provider performs a covered service, Blue Shield of California will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and Benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim Benefits under the Plan and/or law, sue or otherwise begin legal action. Any assignment made without written consent from the Plan will be void and unenforceable.

For additional information about what you're responsible for paying, connect with Included Health to learn more about your plan, including out-of-pocket max, copays, and co-insurance. Download the Included Health mobile app, call 855-633-4436 to speak over the phone, or visit includedhealth.com/calpers to connect from a computer.

Independent Contractors

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any Physician, Hospital, or other provider or their employees.

Web Site

Blue Shield of California's Web site is located at includedhealth.com/calpers. Members with Internet access and a Web browser may view and download health care information.

Utilization Review Process

To request a copy of the document describing this Utilization Review, call Included Health at 855-633-4436.

General Provisions

Benefits for Medicare-Eligible Members

Note: The information provided below is based on federal laws and regulations. Therefore this information is subject to change based on changes in those laws and regulations or their interpretation by either the federal government or the courts.

Active Employees and Their Family Members. Except as noted below, an actively employed Subscriber who is eligible for Medicare and the spouse of such Subscriber will receive the full Benefits of this Plan while the Subscriber remains actively employed.

This Plan will no longer be the primary payer for a Subscriber who is an active Employee or a Family Member of an active Employee who is entitled to Medicare because of permanent kidney failure, also known as "End-Stage Renal Disease", after 30 months has elapsed from the date that the Subscriber or Family Member would have been eligible for Medicare Part A on the basis of permanent kidney failure.

Note: If you are under age 65 and have been diagnosed with Lou Gehrig's Disease (ALS), you may be eligible for Medicare during the first month of your eligibility for Social Security Disability benefits. To check eligibility and obtain more information about disability benefits, look at www.ssa.gov on the Web, or call the Social Security Administration at 1-800-772-1213.

This Plan may be the primary payer for those Subscribers who are actively employed and their Family Members who (1) are under age 65 and (2) have Medicare coverage because of a disability.

Retirees and Their Spouses. If you are a retired Subscriber, or the spouse of a retired Subscriber, and are eligible for Medicare because you made the required number of quarterly contributions to the Social Security System, this Plan will be considered secondary to Medicare and payment will be determined according to the provisions outlined under the Coordination of Benefits section.

Retired Employees and their spouses are required to enroll in a supplement to original Medicare plan upon becoming eligible for Medicare Parts A and B. You must contact CalPERS no later than the date you first become eligible for Medicare. You will be provided with information regarding your enrollment into a supplement to original Medicare plan.

Medical Claims Review and Appeals Process

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

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

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

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

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

2. Internal Review

You and/or your Authorized Representative may request a review of an ABD by writing or calling Member Services within 180 days of receipt of an ABD. Your Appeal or Grievance must clearly state your issue, such as the reasons you disagree with the ABD or why you are dissatisfied with the services you received. If you would like Blue Shield of California to consider your Grievance on an urgent basis, please write "urgent" on the request and provide the rationale. Requests for review must be submitted in one of the following ways:

- Call Included Health at 855-633-4436 for information on how to submit a Member Grievance Form to Blue Shield of California; or
- Download a Member Grievance Form from the website at includedhealth.com/calpers; or submit via mail to:

  In writing by sending information to:
  Blue Shield of California
  Appeals and Grievance Department
  P.O. Box 5588
  El Dorado Hills, CA 95762

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

Blue Shield of California will acknowledge receipt of a request for Internal Review by written notice to you and/or your Authorized Representative within 5 business days. Blue Shield of California will then either uphold or reject the ABD within 30 days of the request for Internal Review if it involves

an authorization of services (pre-service Appeal or concurrent Appeal) or within 60 days for services that have already been provided (post-service Appeal).

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

3. Urgent Review

An urgent Appeal is resolved within 72 hours upon receipt of the request, but only if Blue Shield of California determines the Grievance meets one of the following:

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

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

4. Request for Independent External Review

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

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

You and/or your Authorized Representative may request an Independent External Review no later than 4 months from the date of receipt of the FABD. The type of services in dispute must be a covered Benefit. For cases involving Medical Judgment, you and/or your Authorized Representative

must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. (See the CalPERS Administrative Review and Administrative Hearing section.)

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

5. Request for CalPERS Administrative Review Process

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

Grievance Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with Included Health by calling 855-633-4436 (TTY/TDD services are available by dialing 711) or by visiting our website at includedhealth.com/calpers.

Grievances

This "Grievances" section describes our Grievance procedure. A Grievance is any expression of dissatisfaction expressed by you or your authorized representative. Our team will review, investigate, and respond to your concern(s) within 30 days from the date your Grievance was filed. You must file your Grievance within 180 days following the incident or action that is subject to your concern(s).

If you want to file an Appeal for a claim or procedure that has been denied, please refer to the process outlined in this "Medical Claims Review and Appeals Process" section.

CalPERS Administrative Review and Administrative Hearing

1. Administrative Review

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

This request must be submitted in writing to CalPERS within 30 days from the date of the FABD for benefit decisions or the independent External Review decision in cases involving Medical Judgment. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed thirty (30) days. For objections to claim processing, the request must be submitted within 30 days of Blue Shield of California affirming its decision regarding the claim or within 60 days from the date you sent the objection regarding the claim to Blue Shield of California and Blue Shield of California failed to respond within 30 days of receipt of the objection.

You may submit your request and completed Authorization form via e-mail to: Health.Appeals@CalPERS.ca.gov;

Or, the request may be mailed to:
CalPERS Strategic Health Operations Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

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

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

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

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

2. Administrative Hearing

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

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

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a Member's case not previously submitted for Administrative Review and independent external review.

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

3. Appeal Beyond Administrative Review and Administrative Hearing

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

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

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

- **Right to records, generally.** The 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 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, you may present information through the opinion of an expert, such as a Physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

Service of Legal Process

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

CalPERS Administrative Review and Administrative Hearing

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

Termination of Group Membership/Continuation of Coverage

Termination of Benefits

Coverage for you or your dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the group agreement is discontinued, (2) the last day of the month in which the Participant's employment terminates, unless a different date has been agreed to between Blue Shield of California and your employer, (3) the end of the period for which the premium is paid, or (4) the last day of the month in which you or your dependents become ineligible. A spouse also becomes ineligible following legal separation from the Participant, entry of a final decree of divorce, annulment or dissolution of marriage from the Participant. A domestic partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the Continuity of Care and COBRA provisions, there is no right to receive Benefits for services provided following termination of this group agreement.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see your employer about possibly continuing group coverage. Also, see the COBRA provisions described in this booklet for information on continuation of coverage.

Reinstatement

If you cancel or your coverage is terminated, refer to the CalPERS "Health Program Guide."

Cancellation

No Benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Continuity of Care and COBRA provisions in this booklet.

The group agreement also may be cancelled by CalPERS at any time provided written notice is given to Blue Shield of California to become effective upon receipt, or on a later date as may be specified on the notice. Information pertaining to cancellation can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS.

COBRA

Please examine your options carefully before declining this 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.

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled Family Member who lose their regular group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her Family Member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The Benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Termination of Group Membership/Continuation of Coverage

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months. The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible Family Members are also entitled to this 29-month extension).

1. The covered employee's separation from employment for reasons other than gross misconduct.

2. Reduction in the covered employee's hours to less than half-time.

Four "qualifying events" allow an active or retired employee's enrolled Family Member(s) to elect the continuation coverage for up to 36 months. Children born to or placed for adoption with the 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.

1. The employee's or retiree's death (and the surviving Family Member is not eligible for a monthly survivor allowance from CalPERS).

2. Divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.

3. A dependent child ceases to be a dependent child.

4. The primary COBRA Participant becomes entitled to Medicare.

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

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

1. The termination of all employer provided group health plans, or

2. The enrollee fails to pay the required premium(s) on a timely basis, or

3. The enrollee becomes covered by another health plan without limitations as to pre-existing conditions, or

4. The enrollee becomes eligible for Medicare benefits, or

5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.

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

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

Termination of Group Membership/Continuation of Coverage

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the Family and Medical Leave Act, and Labor Code requirements for medical disability.

Payment by Third Parties

Third Party Recovery Process and the Member's Responsibility

If a Member's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no Benefits will be payable under the Plan unless you agree in writing, in a form satisfactory to the plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;

2. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any recovery (defined below) when the recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Member's uninsured or underinsured motorist coverage;

3. Execute a lien in in favor of the Plan for the full amount of Benefits paid by the Plan;

4. Ensure that any recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the plan;

5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any recovery has been obtained;

6. Direct any legal counsel retained by the Member or any other person acting on the Member's behalf to hold that portion of the recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If the Member fails to comply with the above requirements, no Benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the Plan, through deductions from future Benefit payments to the Member or others enrolled through the Member in the plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the you or on your behalf, and without regard to whether you have been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in your name, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on your behalf, such as an attorney-client trust account.

You shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, you shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

Your acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys' fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys' fees and costs incurred in connection with the claims against the third party.

Payment by Third Parties

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If you receive services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from you the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when you receive payment or reimbursement for medical expenses.

Workers' Compensation

No Benefits are provided for or 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 Blue Shield of California provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of Benefits provided by Blue Shield of California for the treatment of the injury or disease as reflected by the providers' usual billed charges.

Coordination of Benefits (Not applicable to the Outpatient Prescription Drug Program)

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

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

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

Effect on Benefits

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

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

and services of all the plans do not exceed 100% of the Allowable Expense. The Benefit payment by this Plan will never be more than the sum of the Benefits that would have been paid if you were covered under this Plan only.

If this Plan is a secondary carrier with respect to a Plan Member and Blue Shield of California 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 Blue Shield of California to obtain confirmation from the other plan that the benefits claimed have not previously been paid.

Order of Benefits Determination

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

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

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

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

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

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

   c. the plan of the noncustodial parent of the child;

   d. if the noncustodial parent has remarried, the plan of the stepparent married to the parent without custody of the child.

4. Regardless of paragraph 3 above, if there is a court decree that otherwise establishes a parent's financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of that parent shall be the primary carrier.

5. If the above rules do not apply, the plan which has covered the Plan Member for the longer period of time shall be the primary carrier, except for:

a. A plan covering a Plan Member as a laid-off or retired Employee or the dependent of a laid-off or retired Employee will determine its benefits after any other plan covering that person as other than a laid-off or retired Employee or their dependent (This does not apply if either plan does not have a provision regarding laid-off or retired Employees.); or

b. Two plans that have the same effective date will split Allowable Expense equally between the two plans.

Definitions

Allowable Expense — A charge for services or supplies which is considered covered in whole or in part under at least one of the plans covering the Plan Member.

Explanation of Benefits — The statement sent to a Member by their health insurance company listing services provided, amount billed, eligible expenses and payment made by the health insurance company. HMO plans often provide health care services for Members within specific provider networks and may not provide an Explanation of Benefits for Covered Services.

Other Plan — Any blanket or franchise insurance coverage, group service plan contracts, group practice or any other prepayment coverage on a group basis, any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, Employee benefit organization plans, or Medicare.

Primary Carrier — A plan which has primary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and will have its benefits determined first without regard to the possibility that another plan may cover some expenses.

Secondary Carrier — A plan which has secondary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and may reduce its benefit payments after the primary carrier's benefits are determined first.

Plan Member Liability When Payment is Made by PERS Gold

When Covered Services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERS Gold, the Plan Member is responsible only for any applicable Deductible and/or Copayment/Coinsurance. However, if Covered Services are rendered by a Non-Preferred Provider or a Non-Participating Pharmacy, the Member is responsible for any amount PERS Gold 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.

In the Event of Insolvency

If PERS Gold should become insolvent and no payment, or partial payment, is made for Covered Services, the Plan Member is responsible for any charges incurred, regardless of the status of the provider who renders the services. Providers may bill the Plan Member directly, and the Member will have no recourse against the California Public Employees' Retirement System, its officers, or employees for reimbursement of his or her expenses.

Outpatient Prescription Drug Program

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Benefit Program is administered by Optum Rx®. This program will pay for Prescription Drugs which are: (a) prescribed by a Prescriber in connection with a covered illness, condition, or accidental injury; (b) dispensed by a registered pharmacist; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs section. All Prescription Drugs are subject to clinical utilization review when dispensed and to the exclusions listed in the Outpatient Prescription Drug Exclusions. A valid prescription is a written order issued by a licensed Prescriber for the purpose of dispensing a Drug and shall meet all federal/state regulations as required by law.

The Plan's Outpatient Prescription Drug Benefit Program is designed to save you and the Plan money without compromising safety and effectiveness standards. You are encouraged to ask your Prescriber to prescribe Generic Medications or Medications on the Optum Rx® Preferred Drug List whenever possible. Members can still receive any covered Medication, and your Prescriber still maintains the choice of Medication prescribed but this may increase your financial responsibility. All Prescriptions will be filled with an FDA-approved bioequivalent Generic, if one exists, unless your Physician specifies otherwise.

A medication may be excluded when there is a same or similar drug (one with the same active ingredient or same therapeutic effect) available under the Prescription Drug Benefit and the excluded medication offers no unique therapeutic benefits compared to covered alternatives.

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

Go to welcome.optumrx.com/calpers to check your plan's formulary to see if your Medication is covered. You can also search for lower cost alternatives.

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

Classification of Medications

The lists of Specialty Medications (available only through Optum® Specialty Pharmacy), and Maintenance Medications are subject to change. To find out which Medications are impacted, Members can visit Optum Rx® on-line at welcome.optumrx.com/calpers or call Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711), 24 hours a day, 7 days a week.

Copayment Structure

Your Copayment will vary depending on whether you use retail versus Home Delivery; whether you select Generic, Preferred and Non-Preferred Brand Name Medications; whether your drug is a Maintenance Medication; and, for Brand-Name drugs, whether a Generic Drug equivalent is available.

Maintenance Medication can be filled for two Copayments for up to a 90-day supply at Home Delivery or one Copayment for a 30-day supply at retail.

The Copayment applies to each Prescription Order and to each refill. The Copayment is not reimbursable and cannot be used to satisfy any Deductible requirement. Under some circumstances, your Prescription may cost less than the actual Copayments, and you will be charged the lesser amount.

The Plan's incentive Copayment structure includes Generic, Preferred and Non-Preferred Brand-Name Tier 1, Tier 2 and Tier 3 medications. The Member has an incentive to use Generic and Preferred Brand-Name Drugs, at Optum Home Delivery or retail Pharmacies. Your Copayment will vary depending on whether you use retail versus Home Delivery; whether you select Generic, Preferred or Non-Preferred Brand Name Medications- Tier 1, Tier 2 and Tier 3; whether your drug is a Maintenance Medication; and, for Brand-Name Drugs, whether a Generic Drug equivalent is available.

Maintenance Medication can be filled for two Copayments for up to a 90-day supply at Home Delivery or one Copayment for a 30-day supply at retail. The Copayment applies to each Prescription Order and to each refill. The Copayment is not reimbursable and cannot be used to satisfy any Deductible requirement. Under some circumstances, your Prescription may cost less than the actual Copayments, and you will be charged the lesser amount.

Coinsurance, "Member Pays the Difference" and "Partial Copay Waiver"

- Erectile or Sexual Dysfunction Drugs are subject to a 50% Coinsurance.

- "Member Pays the Difference" program: If a Brand-Name Medication is selected when a Generic equivalent is available, Members will pay the difference in cost between the Brand Name Medication and the Generic equivalent, plus the Generic Copayment.

- You may apply for a Member Pays the Difference Exception by contacting Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) to request an Exception form. Your Physician must document the Medical Necessity for the Brand product(s) versus the available Generic alternative(s).

- You may apply for a Partial Copay Waiver Exception only for Non-Preferred Brand Medications by contacting Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) to request an Exception form. Your Physician must document the Medical Necessity for the Non-Preferred Brand product(s) versus the available Generic or Preferred Brand alternative(s).

- Partial Copay Waiver Exception and Member Pays the Difference Exception authorizations will be entered from the date of the approval. Retroactive reimbursement requests will not be granted. Erectile or Sexual Dysfunction Medications are excluded.

Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a Participating Pharmacy by using your PERS Gold Basic PPO ID card.

There are many Participating Pharmacies outside California that will also accept your PERS Gold Basic PPO ID card. At Participating Pharmacies, simply show your ID card to receive a 30-day supply by paying either:

- $5 Copayment for Tier 1 Medication

- $20 Copayment for Tier 2 Medication

- $50 copayment for Tier 3 Medication

- Partial Copay Waiver not applicable in a retail pharmacy

If you have opted into the MSMS program, for any new Prescriptions, you will be able to fill your Maintenance Prescription for two 30-day fills before you will be required to move the Prescription to Home Delivery. If you have opted out of the MSMS program, you will be able to fill all of your Prescriptions for a 30-day fill going forward. If the Pharmacy does not accept your ID card and is a Non-Participating Pharmacy, there may be an additional charge to you.

To find a Participating Pharmacy close to you, simply visit the Optum Rx® website at welcome.optumrx.com/calpers, or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711). For more information on Optum Home Delivery visit the Optum Rx® website at welcome.optumrx.com/calpers, or call Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711).

Mail Service Member Select Program (MSMS)

Your plan can help you save on the Medication you take regularly. Members can switch to Optum Home Delivery for a reduced Copayment or you can keep filling at retail with no Copayment savings – but you must make a choice by opting-in or out of the program.

- Opting-in: By opting-in to the program you are deciding to fill your Maintenance Medications at Home Delivery going forward. This will allow you a discounted Copayment when filling your Prescriptions. This does not include non-Maintenance Medications which can be filled at retail for a 30-day supply. Also, Members are allowed two grace fills at retail for new Prescriptions of Medications you will be taking regularly (these are called Maintenance Medications) after which fills must be moved to Home Delivery.

- Opting-out: By opting-out of the program you are deciding to fill your Maintenance Medications for a 30-day supply at retail where you will be paying a 30-day Copayment for each 30-day fill.

Members may contact OptumRx either by phone or online to choose your option to fill 90-days at Home Delivery or not. If you do not make a decision, your Maintenance Medication at retail will reject on the third fill. If you choose to remain at retail, you may continue to fill your Maintenance Medication for a 30-day supply. Copayment comparison:

Home Delivery: 90-day supply:

- Tier 1 medication $10
- Tier 2 medication $40
- Tier 3 medication $100

Retail: Limited to 30-day supply:

- Tier 1 medication $5
- Tier 2 medication $20

- Tier 3 medication $50

Please note that all Prescriptions mailed by the Optum Home Delivery Program will be subject to the Copayments above regardless of quantity.

Tier 3 Medication can be purchased for $70 Copayment with an approved Partial Copay Waiver.

- **Convenience:** Your medication is delivered to your home by mail.
- **A toll-free Member Services number:** Your questions can be answered by contacting Optum Rx® Member Services Representative at 1-855-505-8110 (TTY users call 711).

How to use Optum Home Delivery

If you must take Medication on an ongoing basis, Optum Home Delivery is ideal for you. To get started with home delivery, select from one of the following options:

1. Ask your Prescriber to prescribe Maintenance Medications for up to a 90-day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.

2. Ask your Prescriber to send your Prescription to Optum Rx® electronically (known as e-prescribing) or to fax the Prescription. Optum Rx® can only accept faxed Prescriptions from Prescribers.

3. Set up an online account at welcome.optumrx.com/calpers. Then, log in and select Get Started. Choose which Medication you would like to receive through Optum Home Delivery.

4. Call Optum Rx® at 1-855-505-8110 (TTY users call 711), 24 hours a day, 7 days a week. With your permission, we can contact your doctor's office on your behalf to set up home delivery.

5. Complete and return a New Prescription Order form to Optum Rx®. Forms can be downloaded from welcome.optumrx.com/calpers.

    a. Along with your completed form, you must send the following to Optum Rx®:

    1. The original Prescription Order(s) – Photocopies are not accepted.

    2. If you are not paying with a credit card, you must include a check or money order payable to Optum Rx® for an amount that covers your Copayment for each Prescription.

To order home delivery refills from Optum Rx®, select one of the following options:

1. Log in to your online account. Select the Medications you wish to refill.

2. Download the Optum Rx® App for your Apple® or Android™ smartphone. Open the app, select Medicine Cabinet. Choose which Medication you want to refill.

3. Call Optum Rx® at 1-855-505-8110 (TTY users call 711) and we can help you refill your Medication.

4. By mail: Complete and return the prepopulated refill form that was included in your Medication package from your previous order with Optum Rx®. Optum Rx® also includes a return envelope in each order.

Outpatient Prescription Drug Program

New Prescriptions Optum Rx® home delivery Pharmacy receives directly from your doctor's office. After the Pharmacy receives a Prescription from a health care provider, it will be filled immediately. It is important that you respond if you are contacted by the Pharmacy to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills of your Drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your Drug. You can cancel scheduled refills if you have enough of your Medication or if your Medication has changed. If you choose not to use our automatic refill program, please contact your Pharmacy 15 days before you think the Drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of the automatic refill program, which automatically prepares mail-order refills, please contact us by calling Optum Rx® at 1-855-505-8110 (TTY users call 711).

To confirm your order before shipping, please make sure to let the Pharmacy know the best ways to contact you. Please call Optum Rx® to give us your preferred phone number.

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

Take your Prescription to any Participating Pharmacy*. Present your PERS Gold Basic PPO ID card to the pharmacist. The pharmacist will fill the Prescription for up to a 30-day supply of Medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.

*Limitations may apply.

Non-Participating Pharmacy/Out-of-Network/Foreign Prescription Claims

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

Example of a Direct Reimbursement Claim for a 30-day Tier 2 Medication*	
Retail Pharmacy charge to you	$48
Minus the Optum Rx® Negotiated Network Amount on a Tier 2 Medication	-$30

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
Plus, you Copayment for a Tier 2 Medication	$20
Your total financial cost would be	$38

If you had used your ID Card at a Participating Pharmacy, the Pharmacy would only charge the Plan $30 for the Drug, and your financial cost would only have been the $20 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.

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.

Vacation Overrides: Members are generally allowed up to a 30-day supply, 2 times per medication, per rolling year.

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 an Optum Rx® Prescription Reimbursement Claim Form and mail the form along with your Pharmacy receipt to Optum Rx®. Receipts must be submitted in English. For additional claim reimbursement information, visit the Optum Rx® website at welcome.optumrx.com/calpers, or call Optum Rx® at 1-855-505-8110 (TTY users call 711).

Reimbursement for Drugs will be limited to those obtained while you are traveling or temporarily outside of the United States and will be subject to the same restrictions and coverage limitations as set forth in this Evidence of Coverage document. Excluded from coverage are foreign Drugs for which there is no approved U.S. equivalent, Experimental or Investigational Drugs, or Drugs not covered by the Plan (e.g., Drugs used for cosmetic purposes, etc.). Please refer to the Outpatient Prescription Drug Exclusions section.

Claims must be submitted within 12 months from the date of purchase.

Direct Reimbursement Claim Forms

To obtain an Optum Rx® Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the website at welcome.optumrx.com/calpers, or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711). 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, qualify for coverage if the active ingredients: (a) require a Prescription; (b) are FDA approved; and (c) are covered by CalPERS. Compound Medications are subject to Coverage Management Programs.

Under the Compound Management Program, Compound Medications can be excluded if: (1) there is an FDA approved alternative available that is more efficacious and safe; (2) contains a bulk chemical that is not FDA approved and is on our bulk exclusion list; or (3) includes a pre-packaged compound kit.

Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copayment. The Copayment for a compound Medication is based on the pricing of each individual Drug used in the compound. Compound Medications that contain more than one ingredient will be subject to the applicable Copayment tier of the highest cost ingredient. To verify if a Compound Medication is covered or for a list of compounding Pharmacies, please call Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) for details. Please note that certain fees charged by the compounding Pharmacies may not be covered by your insurance. Compounded prescriptions may undergo a Prior Authorization review.

If a Participating Pharmacy or a Non-Participating Pharmacy is not able to bill online, you will be required to pay the full cost of the compound Medication at the time of purchase and then submit a direct claim for reimbursement. To receive reimbursement, complete the Optum Rx® Prescription Reimbursement Claim Form and mail it to the address indicated on the form. Reimbursement will only be available for covered Drugs in accordance with the Plan provisions. Please see the "Non-Participating Pharmacy/Out-of-Network/Foreign Prescription Claims" section for details on reimbursement for Drugs provided by a Non-Participating Pharmacy.

How to submit a payment to Optum Rx®

You should always submit a payment to Optum Rx® when you order Prescriptions through Optum Rx® Home Delivery, just as if you were ordering a Prescription from a retail Pharmacy. Optum Rx® accepts the following as types of payment methods:

- Check/Money Order
- Credit Card/Debit Card - Visa®, MasterCard®, Discover®, American Express®
- ACH Payments
- Ship and Bill –Members are sent an invoice with their order instead of payment being collected when order is placed. Contact Optum Rx® if you would like more information.
- Easy Pay – Allows members to break up payment into 3 separate installments. This is done on a per fill basis and can be done when members call into Optum Rx® or setup a fill on-line.

Optum Rx® recommends keeping a credit card on file for Copayments. You can securely set up your credit card through your online account or by calling Optum Rx®. Then, each time you refill a Prescription, Optum Rx® will bill the copayment amount to the default credit card on file.

Go to welcome.optumrx.com/calpers to check your plan's formulary to see if your medication is covered. You can also search for lower cost alternatives.

Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include, but are not limited to the Step Therapy and Prior Authorization Program/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan. **The Plan reserves the right to exclude, discontinue or limit coverage of Drugs or a class of Drugs, at any time following a review.**

The Plan may implement additional new programs designed to ensure that Medications dispensed to its Members are covered under this Plan. **As new Medications are developed, including generic versions of Brand-Name Medications, or when Medications receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those Medications or class of Medications under the Plan. Any benefit payments made for a Prescription Medication will not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that Medication at a later date.**

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

Step Therapy

The Step Therapy program helps you and your Prescriber choose a lower-cost medication as the first step in treating your health condition. Before certain targeted Brand Name Drugs are covered, this program requires that you try a different medication (usually a generic) as the first step in treating your health condition. If you cannot or will not make the change, there are the following options:

- If the change is not clinically appropriate, your Prescriber may request a prior authorization.
- If you do not make the change, your targeted Brand Drug will not be covered and you will have to pay the full cost of the Drug.

To find out if your medication is subject to Step Therapy contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) or visit welcome.optumrx.com/calpers.

Prior Authorization/Point of Sale Utilization Review Program

Some prescriptions require a prior authorization to make sure your prescription meets your plan's coverage rules. When you talk with your Prescriber, use the pricing tool on the Optum Rx® App to help confirm whether you need a prior authorization for your medication and if there are any alternatives that meet the plan's coverage rules. You can also talk about what you need to do to get your medication. Approvals for prior authorizations can be granted for up to one year; however, the timeframe may be greater or less, depending on the medication. You and your prescriber will receive notification from Optum Rx® of the prior authorization outcome within a few days. Some medications that require prior authorization may be subject to quantity limits.

Outpatient Prescription Drug Program

Please visit the Optum Rx® website at welcome.optumrx.com/calpers, use the Drug Pricing tool in the Optum Rx® App or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) to determine if your medication requires prior authorization.

Optum® Specialty Pharmacy Services ("Optum® Specialty Pharmacy")

The Optum® Specialty Pharmacy offers convenient access and delivery of Specialty Medications (as defined in this Evidence of Coverage booklet), many of which are injectable, as well as personalized service and educational support. An Optum® Specialty Pharmacy patient care representative will be your primary contact for ongoing delivery needs, questions, and support.

To obtain Specialty Medications, you or your Prescriber should call Optum® Specialty Pharmacy at 1-855-427-4682. Optum® Specialty Pharmacy hours of operation are 8:30 AM to 10:00 PM EST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact Optum® Specialty Pharmacy at 1-855-427-4682 for specific coverage information.

Specialty Medications will be limited to a maximum 30-day supply.

Specialty Preferred Medication - Specialty Preferred Medication strategies control costs and maintain quality of care by encouraging prescribing toward a clinically effective therapy. This program requires a Member to try the preferred Specialty Medication(s) within the Drug class prior to receiving coverage for the non-preferred Medication. If you don't use a preferred Specialty Medication, your Prescription may not be covered and you may be required to pay the full cost. The Member has the opportunity to have the Prescriber change the Prescription to the preferred Medication or have the Prescriber submit a request for coverage through an exception. Clinical exception requests are reviewed to determine if the non-preferred Medication is Medically Necessary for the Member.

Outpatient Prescription Drug Exclusions

Except as required by law, the following are excluded under the Outpatient Prescription Drug Program:

1. Non-medical devices, including but not limited to: Durable Medical Equipment, digital therapies, support garments, continuous glucose meters, appliances and supplies regardless of their intended use, even if prescribed by a physician. Exceptions: Select insulin, diabetic supplies and agents used to administer or manage specific conditions are covered with a valid prescription.*
2. Off label use of FDA approved Drugs**, if determined inappropriate through Optum Rx® Coverage Management Programs.
3. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through Optum Rx® Coverage Management Programs.
4. Over-the-Counter (OTC), Behind-the-Counter (BTC) or medicines obtainable without a Prescriber's Prescription. Exceptions: Select scheduled cough and cold products and select insulin, select opioid reversal agents, diabetic supplies and agents used to administer or manage specific conditions are covered with a valid prescription.
5. 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., multivitamins, and pediatric vitamins), except Prescriptions for single agent vitamin D, vitamin K, vitamin B12 injections, and folic acid.
6. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses) except as required by law.
7. Charges for the purchase of blood or blood plasma.
8. Hypodermic needles and syringes, except as required for the administration of a covered Drug.

9. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
10. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or Medication prescribed for experimental indications.
11. Any Drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
12. Professional charges for the administration of Prescription Drugs or injectable insulin. *
13. Any charges for immunization agents, except as required by law. *
14. Any charges for desensitization products, allergy, serum or biological sera including the administration thereof. *
15. 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.
16. Reimbursement of charges from a non-Outpatient facility for Drugs or Medications taken by, or administered to, a Plan Member.
17. Refills of any Prescription in excess of the number of refills specified by a Prescriber as allowed per federal/state laws.
18. Any Drugs or Medicines dispensed more than one year following the date of the Prescriber's Prescription Order as allowed per federal/state laws. Note, controlled substances may be less than one year depending on federal/state laws.
19. Any Participating Pharmacy or non-Participating Pharmacy charges for special handling and/or shipping costs.

NOTE: While not covered under the Outpatient Prescription Drug Program benefit, items marked by an asterisk (*) are covered as stated under the Hospital Benefits, Home Health Care, Hospice Care, Home Infusion Therapy and Professional Services provisions of Medical and Hospital Benefits, and Description of Benefits (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

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

Services Covered By Other Benefits

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

Prescription Drug Claim Review and Appeals Process

Optum Rx® manages both the administrative and clinical prescription drug appeals process for CalPERS. If you wish to request a coverage determination, you or your Authorized Representative, may contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711). Member Services will provide you with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to Optum Rx®. If your request is denied, the written response from Optum Rx® is an initial determination and will include your appeal rights. A denial of the request is an Adverse Benefit Determination (ABD), and may be appealed through the Internal Review process described below. Denials of requests for Partial Copayment Waivers and Member Pay the Difference Exceptions are ABDs, and you may appeal them through the Internal Review process. If the appeal is denied through the Internal Review process, it becomes a Final Adverse Benefit Determination (FABD) and for

cases involving Medical Judgment, you may pursue an independent External Review as described below, or for benefit decisions may request a CalPERS Administrative Review.

The cost of copying and mailing medical records required for Optum Rx® to review its determination is the responsibility of you or your Authorized Representative requesting the review.

1. Denial of claims of benefits

Any denial of a claim is considered an ABD and is eligible for Internal Review as described in section 2. below. FABDs resulting from the Internal Review process may be eligible for independent External Review in cases involving Medical Judgment, as described in section 4. below.

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

You may request an Internal Review for each Medication denied through Coverage Management Programs within 180 days from the date of the notice of initial benefit denial sent by Optum Rx®. This review is subject to the Internal Review process described in section 2. below.

Optum Rx®
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for Prescription Drugs are not payable when first submitted to Optum Rx®. If Optum Rx® determines that a claim is not payable in accordance with the terms of the Plan, Optum Rx® will notify you in writing explaining the reason(s) for nonpayment.

If the claim has erroneous or missing data that may be needed to properly process the claim, you may be asked to resubmit the claim with complete information to Optum Rx®. If after resubmission the claim is determined to be payable in whole or in part, Optum Rx® 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, Optum Rx® will inform you in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the denial made by Optum Rx®, you may request an Internal Review as described in section 2. below.

2. Internal Review

You may request a review of an ABD by writing to Optum Rx® within 180 days of receipt of the ABD. Requests for Internal Review should be directed to:

Optum Rx®
Prior Authorization Department
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799

The request for review must clearly state the issue of the review and include the identification number listed on the Optum Rx® Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support

the Medical Necessity of the service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale. (See definition of "Urgent Review" below.)

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the request for Internal Review. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

You will be provided, upon request and free of charge, a copy of the criteria or guidelines used in making the decision and any other information related to the determination. To make a request, contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711).

Optum Rx® will acknowledge receipt of your request within 5 calendar days. For standard reviews of prior authorization of Prescription services (Pre-Service Appeal or Concurrent Appeal), Optum Rx® will provide a determination within 30 days of the initial request for Internal Review.

For standard reviews of Prescriptions or services that have been provided (Post-Service Appeal), Optum Rx® will provide a determination within 60 days of the initial request for Internal Review.

If Optum Rx® upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the independent External Review process described in section 4. below;

- For FABDs involving benefit, you may pursue the CalPERS Administrative Review process as described in section 5. below.

3. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Optum Rx® determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**

- The standard appeal timeframe would, in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**

- A Physician with knowledge of your medical condition determines that your grievance is urgent.

If Optum Rx® determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you can simultaneously request an independent External Review described below.

4. Request for Independent External Review

FABD's that are eligible for independent External Review are those that involve an element of Medical Judgment. An example of Medical Judgment would be where there has been a denial of a prior authorization on the basis that it is not Medically Necessary. If the FABD decision is based on Medical Judgment, you will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. You may request an independent External Review, in writing, no later than 4 months from the date of the FABD. The Prescription in dispute must be a covered benefit. For cases involving Medical Judgment, you must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. You may also request an independent External Review if Optum Rx® fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

5. Request for CalPERS Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you may submit a request for CalPERS Administrative Review. You must exhaust the Optum Rx® Internal Review process and the independent External Review process, when applicable, prior to submitting a request for a CalPERS Administrative Review. See the section entitled "CalPERS Administrative Review and Administrative Hearing."

Outpatient Prescription Drug Definitions

Behind-the-Counter Drugs (BTC) - a Drug product that does not require a Prescription under federal or state law and is available to Members only through facilitation of the pharmacist or Pharmacy staff. The PERS Gold Basic outpatient prescription drug program does not cover BTC products.

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

Compound Medication – a Drug in which two or more ingredients are combined at a Pharmacy. Does not include mixing, reconstituting, or other such acts that are performed in accordance with directions contained in approved labeling provided by the product's manufacturer and other manufacturer directions consistent with that labeling.

Drug(s) - see definition under Prescription Drugs

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

Incentive Copayment Structure - Members may receive any covered Drug with copayment differentials between a Tier 1 Medication, Tier 2 Medication, and Tier 3 Medication.

Mail Service Member Select (MSMS) - Program allowing members to see a cost savings by filling Medications at mail service for a 90-day supply. Members must make a choice through Optum Rx® between mail service and retail. If members continue using retail, they will be limited to a 30-day supply at a time and pay a 30-day Copayment for each fill. When moving to mail service members will pay 2x Copayment for a 90-day supply. Also, if Members do not make a choice, they will be placed in the mail service program and any fills after the first two grace fills will reject directing members to mail service. Members can opt-out from this product and continue to fill their Maintenance Medications at retail.

However, they must act and opt-out of the product to avoid paying the full cost of their Maintenance Medications.

Maintenance Medications - As determined by CalPERS, a drug that does not require frequent dosage adjustments, usually prescribed to treat a long-term (chronic) condition such as arthritis, diabetes, or high blood pressure.

Medication(s) - see Prescription Drug.

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 Home Delivery Program has agreed to accept as payment in full for Home Delivery 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 the Optum Rx® terms and conditions as a Participating Pharmacy. Members may visit the Optum Rx® website at welcome.optumrx.com/calpers or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication(s) (Non-Preferred Brand-Name Drug(s)) - Medications not listed on the Optum Rx® Preferred Drug List. If you would like to request a copy of the Optum Rx® Preferred Drug List, please visit the Optum Rx® website at welcome.optumrx.com/calpers, or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711). Medications that are recognized as non-preferred and that are covered under your Plan will require the highest (third tier) Copayment.

Over-the-counter Drugs (OTC) - A Drug product that does not require a Prescription under federal or state law. PERS Gold Basic outpatient prescription drug program does not cover OTC products, with the exception of insulin.

Participating Pharmacy - a Pharmacy which is under an agreement with Optum Rx® to provide Prescription Drug services to Plan Members. Members may visit the Optum Rx® website at welcome.optumrx.com/calpers or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711) to locate a Participating Pharmacy.

Preferred Brand-Name Medication(s) (Preferred Brand-Name Drug(s)) - Medication found on the Optum Rx® 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 the Optum Rx® Preferred Drug List, please visit the Optum Rx® website at welcome.optumrx.com/calpers or contact Optum Rx® Member Services at 1-855-505-8110 (TTY users call 711).

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. Optum Rx® and its Pharmacy and Therapeutics Committee conducts a rigorous clinical analysis to evaluate and select each Preferred Drug List Medication for safety, side effects, Drug-to-Drug interactions and cost effectiveness. The preferred product must (1) meet participant's treatment needs, (2) be clinically safe relative to other Drugs with the same indication(s) and therapeutic action(s), (3) be effective for FDA approved indications, (4) have therapeutic merit compared to other effective Drug therapies, and (5) promote appropriate Drug use.

Prescriber - a licensed health care provider with the authority to prescribe Medication.

Prescription(s) - a written order issued by a licensed Prescriber for the purpose of dispensing a Drug and shall meet all federal/state regulations as required by law.

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

Prescription Order(s) - the request for each separate Drug or Medication by a Prescriber and each authorized refill of such request.

Specialty Medication(s) - as determined by CalPERS, a Drug that has 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 high cost.

Specialty Pharmacy - a licensed facility for the purpose of dispensing Specialty Medications.

Tier 1 Medications - Mostly Generic Drugs are listed under Tier 1 and have the lowest Copayments.

Tier 2 Medications - Drugs listed under Tier 2 generally include Preferred Brand-Name Drugs that have lower Copayments than Non-Preferred Brand-Name Drugs.

Tier 3 Medications - Drugs listed under Tier 3 generally have higher Copayments than Preferred Brand-Name Drugs and may include some specialty or high-cost drugs.

Definitions

When any of the following terms are capitalized in this Benefit Booklet, they will have the meaning below. This section should be read carefully.

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

Acute Care - care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Adverse Benefit Determination (ABD) - a decision by Blue Shield of California to deny, reduce, terminate or fail to pay for all or part of a Benefit that is based on:

- Determination of an individual's eligibility to participate in this PPO plan; or
- Determination that a Benefit is not covered; or
- Determination that a Benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Allowable Amount – The maximum amount Blue Shield of California will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Benefit Booklet, the Allowable Amount is:

1. For a Preferred Provider, the amount that the provider and Blue Shield of California have agreed by contract will be accepted as payment in full for the services rendered.

2. For a Non-Preferred Provider who provides Emergency Services:

    a. For Physicians and Hospitals - the Reasonable and Customary amount; or

    b. All other providers – (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under federal law.

3. For a Non-Preferred Provider in California, who provides services other than Emergency Services:

    a. The amount Blue Shield of California would have allowed for a Preferred Provider performing the same service in the same geographical area but not exceeding any stated Benefit maximum;

    b. Non-Preferred dialysis center: for services prior authorized by Blue Shield of California, the amount is the reasonable and customary amount.

4. For a provider outside of California but inside the BlueCard® Service Area, the lower of:

    a. The provider's billed charge, or

    b. The local Blue Plan's Preferred Provider payment or the pricing arrangement required by applicable state or federal law.

5. For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core.

6. For a Non-Preferred Provider outside of California (within the BlueCard® Service Area) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services other than Emergency Services: the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a Non-Preferred Provider performing the same services. Or, if the local Blue Cross and/or Blue Shield plan has no Non-Preferred Provider allowance, the Allowable Amount is the amount for a Non-Preferred Provider in California. Or, if applicable, the amount determined under federal law.

Where required under federal law, the Allowable Amount used to determine your Cost Share may be based on the plan's "qualifying payment amount," which may differ from the amount Blue Shield of California pays the Non-Preferred Provider or facility for Covered Services.

Alternate Care Services Provider - Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Alternative Birthing Center –

1. a birthing room located physically within a Hospital to provide homelike Outpatient maternity facilities, or

2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

Ambulatory Surgery Center - an independent entity not affiliated with a Hospital or a surgery center where there is a 51% majority Physician ownership. The center is freestanding and operates under its own tax identification number (TIN), separate from a Hospital's TIN. These centers do not provide services or accommodations for patients to stay overnight.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an Adverse Benefit Determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Applied Behavioral Analysis (ABA) - the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Authorized Representative - means an individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Blue Shield of California.

Autism Spectrum Disorder - as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Behavioral Health Treatment – professional services and treatment programs, including Applied Behavioral Analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Benefits (Covered Services) - those services which a Member is entitled to receive pursuant to the terms of the Plan.

Definitions

Blue Distinction Centers for Specialty Care (BDCSC) - are Health Care Providers designated by Blue Shield of California as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with Blue Shield of California at the time services are rendered or is available through their affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agrees to accept the Plan payment plus applicable Member Deductibles and Copayments and/or Coinsurance as payment in full for Covered Services.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator – An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee - A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

Christian Science Nursing Facility - A Christian Science Nursing Facility accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc.

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

Close Relative - the spouse, domestic partner, child, brother, sister or parent of a Member.

Continuous Nursing Services (Private Duty Nursing) — Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

Copayment - the amount that a Member is required to pay for specific Covered Services.

Cosmetic Surgery - surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) - those services which a Member is entitled to receive pursuant to the terms of the Plan.

Custodial or Maintenance Care - care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Physician); or care furnished to a Member who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Dental Care and Services - services or treatment on or to the teeth or gums whether or not caused by Accidental Injury, including any appliance or device applied to the teeth or gums.

Disputed Health Care Service - any Health Care Service eligible for coverage and payment under your Plan that has been denied, modified or delayed by Blue Shield of California or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

Doctor of Medicine - a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Domiciliary Care - care provided in a Hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Dues (Rates) - the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

Durable Medical Equipment - equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, required dialysis equipment and medical supplies, and other items that the Plan determines are Durable Medical Equipment.

Emergency Medical Condition - a medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following:

1) placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child);

2) serious impairment to bodily functions;

3) serious dysfunction of any bodily organ or part;

4) danger to yourself or to others; or

5) inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.

Emergency Services – the following services for an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition,

2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the Member.

3) Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general Acute Care Hospital or to an acute psychiatric Hospital; and

4) Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Preferred Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of Outpatient observation or Inpatient or Outpatient stay.

'Stabilize' means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Post-Stabilization Care means Medically Necessary services received after the treating Physician determines the Emergency Medical Condition is stabilized.

Employer (Contractholder) - means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least 101 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for the purposes of buying health care coverage or insurance.

Experimental or Investigational in Nature - any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies shall be considered experimental or investigational if, as determined by Blue Shield of California, at least one of the following elements is met:

1. Requires approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered; or
2. Is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use; or
3. Is not approved or recognized in accordance with accepted professional medical standards, but nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or
4. Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable; or
5. Where the consensus amongst experts in recognized published medical literature is that further studies, research, or experience is necessary to determine effectiveness and net health benefit in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use.

Family - the Participant and all enrolled dependents.

Former Preferred Provider - A Former Preferred Provider is a provider of services to the Member under any of the following conditions:

1. A provider who is no longer available to the Member as a Preferred Provider, but at the time of the provider's contract termination with Blue Shield of California, the Member was receiving Covered Services from that provider for one of the conditions listed in the "Continuity of care with a Former Preferred Provider" table in the Continuity of Care section.

2. A Non-Preferred Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time the Member's coverage with Blue Shield of California became effective, the Member was receiving Covered Services from that provider for one of the conditions listed in the "Continuity of care with a Former Preferred Provider" table in the Continuity of Care section.
3. A provider who is a Preferred Provider with Blue Shield of California but no longer available to the Member as a Preferred Provider because:
   a) The Employer has terminated its contract with Blue Shield of California; and
   b) The Employer currently contracts with a new health plan (insurer) that does not include Blue Shield of California Preferred Provider in its network; and
   c) At the time of the Employer's contract termination the Member was receiving Covered Services from that provider for one of the conditions listed in the "Continuity of care with a Former Preferred Provider table" in the Continuity of Care section.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care - Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and Behavioral Health Treatment. Valid, evidence-based sources establishing Generally Accepted Standards of Mental Health and Substance Use Disorder care include:

1. Peer-reviewed scientific studies and medical literature;

2. Clinical practice guidelines and recommendations of nonprofit Health Care Provider professional associations;

3. Specialty societies and federal government agencies; and

4. Drug labeling approved by the United States Food and Drug Administration.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Health Care Provider - An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: acupuncturist; associate clinical social worker; associate marriage and family therapist or marriage and family therapist trainee; associate professional clinical counselor or professional clinical counselor trainee; audiologist; board certified behavior analyst (BCBA); certified nurse midwife; chiropractor; clinical nurse specialist; dentist; hearing aid supplier; licensed clinical social worker; licensed midwife; licensed professional clinical counselor (LPCC); licensed vocational nurse; marriage and family therapist; massage therapist; naturopath; nurse anesthetist (CRNA); nurse practitioner; occupational therapist; optician; optometrist; pharmacist; physical therapist; Physician; physician assistant; podiatrist; psychiatric/mental health registered nurse; psychologist; psychology trainee or person supervised as required by law; qualified autism service provider or qualified autism service professional certified by a national entity; registered dietician; registered nurse; registered psychological assistant; registered respiratory therapist; speech and language pathologist.

Hospice or Hospice Agency - an entity which provides Hospice services to terminally ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Definitions

Hospital - either 1., 2. or 3. below:

1. a licensed and accredited health facility which is primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis, and which provides such facilities under the supervision of a staff of Physicians and 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, nursing home or home for the aged is not included; or,

2. a psychiatric Hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or,

3. a "psychiatric health facility" as defined in Section 1250.2 of the Health & Safety Code.

Host Blue — the local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the BlueCard Service Area.

Incurred - a charge shall be deemed to be "incurred" on the date the particular service which gives rise to it is provided or obtained.

Infertility –

1) a demonstrated condition recognized by a licensed Physician and surgeon as a cause for Infertility; or

2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Inpatient - an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

Intensive Behavioral Intervention - any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Intensive In-Home Behavioral Health Program - range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental health condition or substance use disorder, put the Member and others at risk of harm.

Intensive Outpatient Program - an Outpatient mental health (or substance use disorder) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least 3 hours per day, 3 times per week.

Inter-Plan Arrangements – Blue Shield of California's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

Life-Threatening Disease or Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Medical Necessity (Medically Necessary) -

1. Benefits are provided only for services which are Medically Necessary.

2. Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield of California, are:

   a. consistent with Blue Shield of California's medical policy; and,

   b. consistent with the symptoms or diagnosis; and,

   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider;

   d. furnished at the most appropriate level which can be provided safely and effectively to the patient: and,

   e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

3. Hospital Inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

4. Inpatient services which are not Medically Necessary include hospitalization:

   a. for diagnostic studies that could have been provided on an Outpatient basis; or,

   b. for medical observation or evaluation; or,

   c. for personal comfort; or,

   d. in a pain management center to treat or cure chronic pain; or

   e. for Inpatient Rehabilitative Care that can be provided on an Outpatient basis.

5. Blue Shield of California reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

This definition does not apply to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder - A Covered Service or product addressing the specific needs of a Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care;

2. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

3. Not primarily for the economic benefit of the disability insurer and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.

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

Member - an employee, annuitant, or Family Member as those terms are defined in Sections 22760, 22772 and code 22775 and domestic partner as defined in Sections 22770 and 22771 of the Government code.

Mental Health and Substance Use Disorder(s) - A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Non-Preferred Home Health Care and Home Infusion Agency - an agency which has not contracted with Blue Shield of California and whose services are not covered unless prior authorized by Blue Shield of California.

Non-Preferred Hemophilia Infusion Provider - a provider that has not contracted with Blue Shield of California to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has not been designated as a contracted hemophilia infusion product provider by Blue Shield of California. Note: Non-Preferred Hemophilia Infusion Providers may include Participating Home Health Care and Home Infusion Agency providers if that provider does not also have an agreement with Blue Shield of California to furnish blood factor replacement products and services.

Non-Preferred Provider - any provider who has not contracted with Blue Shield of California to accept Blue Shield of California's payment, plus any applicable Copayment or amount in excess of specified Benefit maximums, as payment in full for Covered Services.

Occupational Therapy - treatment under the direction of a Physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period - a fixed time period designated by CalPERS to initiate enrollment or change enrollment from one plan to another.

Orthosis (Orthotic) - an orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

Out-of-Area Covered Health Care Services - Medically Necessary Emergency Services, Urgent Services, or Out-of-Area Follow-up Care provided outside the Plan Service Area.

Out-of-Area Follow-up Care - non-emergent Medically Necessary services to evaluate the Member's progress after Emergency or Urgent Services provided outside the service area.

Outpatient - an individual receiving services but not as an Inpatient.

Outpatient Department of a Hospital — any department or facility integrated with the Hospital that provides Outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Outpatient Facility - a licensed facility, not a Physician's office, or a Hospital that provides medical and/or surgical services on an Outpatient basis.

Partial Hospitalization Program / Day Treatment - an Outpatient treatment program that may be free-standing or Hospital-based and provides services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following stabilization.

Participant - an individual who satisfies the eligibility requirements of an Employee, who has been enrolled and accepted by Blue Shield of California, and who has maintained enrollment in accordance with this plan.

Physical Therapy - treatment provided by a Physician or under the direction of a Physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician - a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member - a Doctor of Medicine who has enrolled with Blue Shield of California as a Physician Member.

Plan - the PERS Gold Basic PPO Health Plan.

Plan Service Area - the designated geographical area, approved by the CalPERS Board of Administration, within which a Member must live or work to be eligible for enrollment in this Plan.

Preferred Ambulatory Surgery Center - a licensed ambulatory surgery facility which has contracted with Blue Shield of California to provide surgical services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Home Health Care and Home Infusion Agency - an agency which has contracted with Blue Shield of California to furnish services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion Agency by Blue Shield of California. (See Non-Preferred Home Health Care and Home Infusion Agency definition above.)

Preferred Hospice or Preferred Hospice Agency - an entity which: 1) provides Hospice services to terminally ill Members and holds a license, currently in effect, as a Hospice or a home health which has Medicare certification and 2) either has contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice service Benefits.

Preferred Hospital - a Hospital which has contracted with Blue Shield of California to furnish services and accept reimbursement at negotiated rates, and which has been designated as a preferred Hospital by Blue Shield of California.

Preferred Hemophilia Infusion Provider - a provider that has contracted with Blue Shield of California to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has been designated as a contracted hemophilia infusion provider by Blue Shield of California.

Preferred Physician - a Physician or a Physician Member who has contracted with Blue Shield of California to furnish services and to accept Blue Shield of California's payment, plus applicable Copayments, as payment in full for Covered Services.

Preferred Provider - a Physician, a Hospital, an ambulatory surgery center, an Alternate Care Services Provider, or a home health care and home infusion agency that has contracted with Blue Shield of California to furnish services and to accept Blue Shield of California's payment, plus applicable Copayments, as payment in full for Covered Services.

Preventive Health Services — include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call Included Health at 855-633-4436 for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Prosthesis (Prosthetic) - an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Provider Incentive - An additional amount of compensation paid to a Health Care Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Qualified Autism Service Paraprofessional - an unlicensed and uncertified individual who meets all of the following requirements:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services,
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Professional - a provider who meets all of the following requirements:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism
- Service Provider,
- Is a behavioral service provider who meets the education and experience qualifications under applicable state regulation for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, and
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to applicable state law, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider - either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the person, entity who is nationally certified; or
- A person licensed as a Physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the licensee.

The network of Preferred Provider is limited to licensed Qualified Autism Service Providers who contract with Blue Shield of California and who may supervise and employ Qualified Autism Service

Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Rates (Dues) - the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

Reconstructive Surgery - surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (1) to improve function, or (2) to create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of this surgery for cleft palate procedures.

Rehabilitation or Rehabilitative Care - care furnished primarily to restore an individual's ability to function as normally as possible after a disabling disease, illness, injury or substance use disorder. Rehabilitation or rehabilitative care services consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time. Benefits for services for rehabilitation or rehabilitative care are limited to those specified in the Prior Authorization section.

Residential Care - mental health services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute Inpatient care.

Residential Treatment Facility - a treatment facility where the individual resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and Rehabilitation as the result of a mental disorder or substance use disorder. The facility must be licensed to provide psychiatric treatment of mental disorder, or rehabilitative treatment of substance use disorders according to state and local laws.

Respiratory Therapy - treatment, under the direction of a Physician and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Skilled Nursing Facility - a facility with a valid license issued by the California Department of Health Services as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

Speech Therapy - treatment under the direction of a Physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by diagnosed illness or injury.

Subacute Care - skilled nursing or skilled Rehabilitative Care provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or Speech Therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Third-Party Administrator - The claims payor designated by the Health Plan Purchaser to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Third-Party Administrator.

Total Disability -

1. In the case of an employee or Member 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, in view of the individual's station in life and physical and mental capacity.

2. In the case of a dependent, 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, in view of the individual's station in life.

Urgent Services - Those Covered Services rendered outside of the Plan Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Plan Service Area.

Value-Based Program – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value Based Purchasing Design (VBPD) – A program that provides a set Benefit maximum for certain common medical procedures that have low complication rates and that a Member can schedule in advance. The Benefit maximum is the dollar amount or limit that this Plan will be charged for a particular procedure or service. For this Plan, the VBPD program applies to Inpatient services provided for hip and knee joint replacement (see Section A. Hospital Services).

Virtual Health Care – A service that provides Members access to urgent and primary care, as well as mental health services, through virtual visits available from a smartphone, tablet, or computer. Members can access care or schedule appointments for evaluations based on their clinical history and symptoms. Providers offer medical advice, follow-up care, prescriptions, and education on health promotion, disease prevention, and mental well-being. Virtual Health Care is meant to be integrated to ensure continuity of care through patient education, medication reconciliation, and supporting Members in managing both physical and mental health effectively.

PERS Gold PPO Service Area

County	ZIP Codes
Alameda	94501, 94502, 94505, 94514, 94536, 94537, 94538, 94539, 94540, 94541, 94542, 94543, 94544, 94545, 94546, 94550, 94551, 94552, 94555, 94557, 94560, 94566, 94568, 94577, 94578, 94579, 94580, 94586, 94587, 94588, 94601, 94602, 94603, 94604, 94605, 94606, 94607, 94608, 94609, 94610, 94611, 94612, 94613, 94614, 94615, 94617, 94618, 94619, 94620, 94621, 94622, 94623, 94624, 94649, 94659, 94660, 94661, 94662, 94666, 94701, 94702, 94703, 94704, 94705, 94706, 94707, 94708, 94709, 94710, 94712, 94720, 95377, 95391
Alpine	95646, 96120
Amador	95601, 95629, 95640, 95642, 95644, 95654, 95665, 95666, 95669, 95675, 95685, 95689, 95699
Butte	95901, 95914, 95916, 95917, 95925, 95926, 95927, 95928, 95929, 95930, 95938, 95940, 95941, 95942, 95948, 95954, 95958, 95965, 95966, 95967, 95968, 95969, 95973, 95974, 95976, 95978
Calaveras	95221, 95222, 95223, 95224, 95225, 95226, 95228, 95229, 95230, 95232, 95233, 95236, 95245, 95246, 95247, 95248, 95249, 95251, 95252, 95254, 95255, 95257
Colusa	95912, 95932, 95950, 95955, 95957, 95970, 95979, 95987
Contra Costa	94505, 94506, 94507, 94509, 94511, 94513, 94514, 94516, 94517, 94518, 94519, 94520, 94521, 94522, 94523, 94524, 94525, 94526, 94527, 94528, 94529, 94530, 94531, 94547, 94548, 94549, 94551, 94553, 94556, 94561, 94563, 94564, 94565, 94569, 94570, 94572, 94575, 94582, 94583, 94595, 94596, 94597, 94598, 94706, 94707, 94708, 94801, 94802, 94803, 94804, 94805, 94806, 94807, 94808, 94820, 94850
Del Norte	95531, 95532, 95538, 95543, 95548, 95567
El Dorado	95613, 95614, 95619, 95623, 95629, 95633, 95634, 95635, 95636, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95720, 95721, 95726, 95735, 95762, 96142, 96150, 96151, 96152, 96154, 96155, 96156, 96157, 96158
Fresno	93210, 93234, 93242, 93245, 93602, 93605, 93606, 93607, 93608, 93609, 93611, 93612, 93613, 93616, 93618, 93619, 93620, 93621, 93622, 93624, 93625, 93626, 93627, 93628, 93630, 93631, 93634, 93640, 93641, 93642, 93646, 93648, 93649, 93650, 93651, 93652, 93654, 93656, 93657, 93660, 93662, 93664, 93667, 93668, 93675, 93701, 93702, 93703, 93704, 93705, 93706, 93707, 93708, 93709, 93710, 93711, 93712, 93714, 93715, 93716, 93717, 93718, 93720, 93721, 93722, 93723, 93724, 93725, 93726, 93727, 93728, 93729, 93730, 93737, 93740, 93741, 93744, 93745, 93747, 93750, 93755, 93760, 93761, 93764, 93765, 93771, 93772, 93773, 93774, 93775, 93776, 93777, 93778, 93779, 93786, 93790, 93791, 93792, 93793, 93794, 93844, 93888
Glenn	95913, 95920, 95939, 95943, 95951, 95963, 95970, 95988
Humboldt	95501, 95502, 95503, 95511, 95514, 95518, 95519, 95521, 95524, 95525, 95526, 95528, 95534, 95536, 95537, 95540, 95542, 95545, 95546, 95547, 95549, 95550, 95551, 95552, 95553, 95554, 95555, 95556, 95558, 95559, 95560, 95562, 95564, 95565, 95569, 95570, 95571, 95573, 95589

PERS Gold PPO Service Area

Imperial	92004, 92222, 92225, 92227, 92231, 92232, 92233, 92243, 92244, 92249, 92250, 92251, 92257, 92259, 92266, 92273, 92274, 92275, 92281, 92283
Inyo	92328, 92384, 92389, 93513, 93514, 93515, 93522, 93526, 93527, 93530, 93542, 93545, 93549
Kern	93203, 93205, 93206, 93215, 93216, 93220, 93222, 93224, 93225, 93226, 93238, 93240, 93241, 93243, 93249, 93250, 93251, 93252, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314, 93380, 93383, 93384, 93385, 93386, 93387, 93388, 93389, 93390, 93501, 93502, 93504, 93505, 93516, 93518, 93519, 93523, 93524, 93527, 93528, 93531, 93536, 93554, 93555, 93556, 93558, 93560, 93561, 93581, 93596
Kings	93202, 93204, 93212, 93230, 93232, 93239, 93242, 93245, 93246, 93266, 93631, 93656
Lake	95422, 95423, 95424, 95426, 95435, 95443, 95451, 95453, 95457, 95458, 95461, 95464, 95467, 95469, 95485, 95493
Lassen	96006, 96009, 96056, 96068, 96109, 96113, 96114, 96117, 96119, 96121, 96123, 96127, 96128, 96130, 96132, 96136, 96137
Los Angeles	90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90009, 90010, 90011, 90012, 90013, 90014, 90015, 90016, 90017, 90018, 90019, 90020, 90021, 90022, 90023, 90024, 90025, 90026, 90027, 90028, 90029, 90030, 90031, 90032, 90033, 90034, 90035, 90036, 90037, 90038, 90039, 90040, 90041, 90042, 90043, 90044, 90045, 90046, 90047, 90048, 90049, 90050, 90051, 90052, 90053, 90054, 90055, 90056, 90057, 90058, 90059, 90060, 90061, 90062, 90063, 90064, 90065, 90066, 90067, 90068, 90069, 90070, 90071, 90072, 90073, 90074, 90075, 90076, 90077, 90078, 90079, 90080, 90081, 90082, 90083, 90084, 90086, 90087, 90088, 90089, 90091, 90093, 90094, 90095, 90096, 90099, 90134, 90189, 90201, 90202, 90209, 90210, 90211, 90212, 90213, 90220, 90221, 90222, 90223, 90224, 90230, 90231, 90232, 90239, 90240, 90241, 90242, 90245, 90247, 90248, 90249, 90250, 90251, 90254, 90255, 90260, 90261, 90262, 90263, 90264, 90265, 90266, 90267, 90270, 90272, 90274, 90275, 90277, 90278, 90280, 90290, 90291, 90292, 90293, 90294, 90295, 90296, 90301, 90302, 90303, 90304, 90305, 90306, 90307, 90308, 90309, 90310, 90311, 90312, 90401, 90402, 90403, 90404, 90405, 90406, 90407, 90408, 90409, 90410, 90411, 90501, 90502, 90503, 90504, 90505, 90506, 90507, 90508, 90509, 90510, 90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609, 90610, 90623, 90630, 90631, 90637, 90638, 90639, 90640, 90650, 90651, 90652, 90660, 90661, 90662, 90670, 90671, 90701, 90702, 90703, 90704, 90706, 90707, 90710, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90723, 90731, 90732, 90733, 90734, 90744, 90745, 90746, 90747, 90748, 90749, 90755, 90801, 90802, 90803, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90813, 90814, 90815, 90822, 90831, 90832, 90833, 90840, 90842, 90844, 90846, 90847, 90848, 90853, 90895, 91001, 91003, 91006, 91007, 91008, 91009, 91010, 91011, 91012, 91016, 91017, 91020, 91021, 91023, 91024, 91025, 91030, 91031, 91040, 91041, 91042, 91043, 91046, 91066, 91077, 91101, 91102, 91103, 91104, 91105, 91106, 91107, 91108, 91109, 91110, 91114, 91115, 91116, 91117, 91118, 91121, 91123, 91124, 91125, 91126, 91129, 91182, 91184, 91185, 91188, 91189, 91199, 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208, 91209, 91210, 91214, 91221, 91222, 91224, 91225, 91226, 91301, 91302, 91303, 91304, 91305, 91306, 91307, 91308,

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Madera	93601, 93602, 93604, 93610, 93614, 93620, 93622, 93623, 93626, 93636, 93637, 93638, 93639, 93643, 93644, 93645, 93653, 93669, 93720
Marin	94901, 94903, 94904, 94912, 94913, 94914, 94915, 94920, 94924, 94925, 94929, 94930, 94933, 94937, 94938, 94939, 94940, 94941, 94942, 94945, 94946, 94947, 94948, 94949, 94950, 94952, 94956, 94957, 94960, 94963, 94964, 94965, 94966, 94970, 94971, 94973, 94974, 94976, 94977, 94978, 94979, 94998
Mariposa	93601, 93623, 93653, 95306, 95311, 95318, 95321, 95325, 95329, 95338, 95345, 95369, 95389
Mendocino	95410, 95415, 95417, 95418, 95420, 95425, 95427, 95428, 95429, 95432, 95437, 95445, 95449, 95454, 95456, 95459, 95460, 95463, 95466, 95468, 95469, 95470, 95481, 95482, 95488, 95490, 95494, 95585, 95587, 95589
Merced	93610, 93620, 93622, 93635, 93661, 93665, 95301, 95303, 95312, 95315, 95316, 95317, 95322, 95324, 95333, 95334, 95340, 95341, 95343, 95344, 95348, 95360, 95365, 95369, 95374, 95380, 95388
Modoc	96006, 96015, 96054, 96056, 96101, 96104, 96108, 96110, 96112, 96115, 96116, 96134
Mono	93512, 93514, 93517, 93529, 93541, 93546, 96107, 96133
Monterey	93426, 93450, 93451, 93901, 93902, 93905, 93906, 93907, 93908, 93912, 93915, 93920, 93921, 93922, 93923, 93924, 93925, 93926, 93927, 93928, 93930, 93932, 93933, 93940, 93942, 93943, 93944, 93950, 93953, 93954, 93955, 93960, 93962, 95004, 95012, 95039, 95076
Napa	94503, 94508, 94515, 94558, 94559, 94562, 94567, 94573, 94574, 94576, 94581, 94599, 95476
Nevada	95602, 95712, 95724, 95728, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977, 95986, 96111, 96160, 96161, 96162
Orange	90620, 90621, 90622, 90623, 90624, 90630, 90631, 90632, 90633, 90638, 90680, 90720, 90721, 90740, 90742, 90743, 92602, 92603, 92604, 92605, 92606, 92607, 92609, 92610, 92612, 92614, 92615, 92616, 92617, 92618, 92619, 92620, 92623,

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Placer	95602, 95603, 95604, 95610, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95701, 95703, 95713, 95714, 95715, 95717, 95722, 95736, 95746, 95747, 95765, 96140, 96141, 96142, 96143, 96145, 96146, 96148, 96161
Plumas	95915, 95923, 95934, 95947, 95956, 95971, 95980, 95983, 95984, 96020, 96103, 96105, 96106, 96122, 96129, 96135, 96137
Riverside	91752, 92028, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92225, 92226, 92230, 92234, 92235, 92236, 92239, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883
Sacramento	94203, 94204, 94205, 94206, 94207, 94208, 94209, 94211, 94229, 94230, 94232, 94234, 94235, 94236, 94237, 94239, 94240, 94244, 94245, 94247, 94248, 94249, 94250, 94252, 94254, 94256, 94257, 94258, 94259, 94261, 94262, 94263, 94267, 94268, 94269, 94271, 94273, 94274, 94277, 94278, 94279, 94280, 94282, 94283, 94284, 94285, 94287, 94288, 94289, 94290, 94291, 94293, 94294, 94295, 94296, 94297, 94298, 94299, 94571, 95608, 95609, 95610, 95611, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638, 95639, 95641, 95652, 95655, 95660, 95662, 95670, 95671, 95673, 95678, 95680, 95683, 95690, 95693, 95741, 95742, 95757, 95758, 95759, 95763, 95811, 95812, 95813, 95814, 95815, 95816, 95817, 95818, 95819, 95820, 95821, 95822, 95823, 95824, 95825, 95826, 95827, 95828, 95829, 95830, 95831, 95832, 95833, 95834, 95835, 95837, 95838, 95840, 95841, 95842, 95843, 95851, 95852, 95853, 95860, 95864, 95865, 95866, 95867, 95894, 95899
San Benito	93210, 93930, 95004, 95023, 95024, 95043, 95045, 95075
San Bernardino	91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91766, 91784, 91785, 91786, 92242, 92252, 92256, 92267, 92268, 92277, 92278, 92280, 92284, 92285, 92286, 92301, 92304, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92323, 92324, 92325, 92327, 92329, 92331, 92332, 92333, 92334, 92335, 92336, 92337, 92338, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92347, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92363, 92364,

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	92365, 92366, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423, 92427, 92880, 93516, 93555, 93562, 93592
San Diego	91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91934, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 91987, 92003, 92004, 92007, 92008, 92009, 92010, 92011, 92013, 92014, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92036, 92037, 92038, 92039, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92064, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92074, 92075, 92078, 92079, 92081, 92082, 92083, 92084, 92085, 92086, 92088, 92091, 92092, 92093, 92096, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92134, 92135, 92136, 92137, 92138, 92139, 92140, 92142, 92143, 92145, 92147, 92149, 92150, 92152, 92153, 92154, 92155, 92158, 92159, 92160, 92161, 92163, 92165, 92166, 92167, 92168, 92169, 92170, 92171, 92172, 92173, 92174, 92175, 92176, 92177, 92178, 92179, 92182, 92186, 92187, 92191, 92192, 92193, 92195, 92196, 92197, 92198, 92199
San Francisco	94102, 94103, 94104, 94105, 94107, 94108, 94109, 94110, 94111, 94112, 94114, 94115, 94116, 94117, 94118, 94119, 94120, 94121, 94122, 94123, 94124, 94125, 94126, 94127, 94128, 94129, 94130, 94131, 94132, 94133, 94134, 94137, 94139, 94140, 94141, 94142, 94143, 94144, 94145, 94146, 94147, 94151, 94158, 94159, 94160, 94161, 94163, 94164, 94172, 94177, 94188
San Joaquin	94514, 95201, 95202, 95203, 95204, 95205, 95206, 95207, 95208, 95209, 95210, 95211, 95212, 95213, 95214, 95215, 95219, 95220, 95227, 95230, 95231, 95234, 95236, 95237, 95240, 95241, 95242, 95253, 95258, 95267, 95269, 95296, 95297, 95304, 95320, 95330, 95336, 95337, 95361, 95366, 95376, 95377, 95378, 95385, 95391, 95632, 95686, 95690
San Luis Obispo	93252, 93401, 93402, 93403, 93405, 93406, 93407, 93408, 93409, 93410, 93412, 93420, 93421, 93422, 93423, 93424, 93426, 93428, 93430, 93432, 93433, 93435, 93442, 93443, 93444, 93445, 93446, 93447, 93448, 93449, 93451, 93452, 93453, 93454, 93461, 93465, 93475, 93483
San Mateo	94002, 94005, 94010, 94011, 94014, 94015, 94016, 94017, 94018, 94019, 94020, 94021, 94025, 94026, 94027, 94028, 94030, 94037, 94038, 94044, 94060, 94061, 94062, 94063, 94064, 94065, 94066, 94070, 94074, 94080, 94083, 94128, 94303, 94401, 94402, 94403, 94404, 94497
Santa Barbara	93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93254, 93427, 93429, 93434, 93436, 93437, 93438, 93440, 93441, 93454, 93455, 93456, 93457, 93458, 93460, 93463, 93464
Santa Clara	94022, 94023, 94024, 94035, 94039, 94040, 94041, 94042, 94043, 94085, 94086, 94087, 94088, 94089, 94301, 94302, 94303, 94304, 94305, 94306, 94309, 94550, 95002, 95008, 95009, 95011, 95013, 95014, 95015, 95020, 95021, 95023, 95026, 95030, 95031, 95032, 95033, 95035, 95036, 95037, 95038, 95042, 95044, 95046,

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Santa Cruz	95001, 95003, 95005, 95006, 95007, 95010, 95017, 95018, 95019, 95033, 95041, 95060, 95061, 95062, 95063, 95064, 95065, 95066, 95067, 95073, 95076, 95077
Shasta	96001, 96002, 96003, 96007, 96008, 96011, 96013, 96016, 96017, 96019, 96022, 96025, 96028, 96033, 96040, 96047, 96049, 96051, 96056, 96059, 96062, 96065, 96069, 96070, 96071, 96073, 96076, 96079, 96084, 96087, 96088, 96089, 96095, 96096, 96099
Sierra	95910, 95922, 95936, 95944, 95960, 96105, 96118, 96124, 96125, 96126
Siskiyou	95568, 96014, 96023, 96025, 96027, 96031, 96032, 96034, 96037, 96038, 96039, 96044, 96050, 96057, 96058, 96064, 96067, 96085, 96086, 96091, 96094, 96097, 96134
Solano	94503, 94510, 94512, 94533, 94534, 94535, 94571, 94585, 94589, 94590, 94591, 94592, 95616, 95618, 95620, 95625, 95687, 95688, 95690, 95694, 95696
Sonoma	94515, 94922, 94923, 94926, 94927, 94928, 94931, 94951, 94952, 94953, 94954, 94955, 94972, 94975, 94999, 95401, 95402, 95403, 95404, 95405, 95406, 95407, 95409, 95412, 95416, 95419, 95421, 95425, 95430, 95431, 95433, 95436, 95439, 95441, 95442, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471, 95472, 95473, 95476, 95480, 95486, 95487, 95492, 95497
Stanislaus	95230, 95304, 95307, 95313, 95316, 95319, 95322, 95323, 95326, 95328, 95329, 95350, 95351, 95352, 95353, 95354, 95355, 95356, 95357, 95358, 95360, 95361, 95363, 95367, 95368, 95380, 95381, 95382, 95385, 95386, 95387, 95397
Sutter	95626, 95645, 95659, 95668, 95674, 95676, 95692, 95837, 95948, 95953, 95957, 95982, 95991, 95992, 95993
Tehama	95963, 95973, 96021, 96022, 96029, 96035, 96055, 96059, 96061, 96063, 96074, 96075, 96076, 96078, 96080, 96090, 96092
Trinity	95526, 95527, 95552, 95563, 95595, 96010, 96024, 96041, 96046, 96048, 96052, 96076, 96091, 96093
Tulare	93201, 93207, 93208, 93212, 93215, 93218, 93219, 93221, 93223, 93227, 93235, 93237, 93238, 93244, 93247, 93256, 93257, 93258, 93260, 93261, 93262, 93265, 93267, 93270, 93271, 93272, 93274, 93275, 93277, 93278, 93279, 93282, 93286, 93290, 93291, 93292, 93527, 93603, 93615, 93618, 93631, 93633, 93641, 93646, 93647, 93654, 93666, 93670, 93673
Tuolumne	95305, 95309, 95310, 95311, 95321, 95327, 95329, 95335, 95346, 95347, 95364, 95370, 95372, 95373, 95375, 95379, 95383
Ventura	90265, 91304, 91307, 91311, 91319, 91320, 91358, 91359, 91360, 91361, 91362, 91377, 93001, 93002, 93003, 93004, 93005, 93006, 93007, 93009, 93010, 93011, 93012, 93013, 93015, 93016, 93020, 93021, 93022, 93023, 93024, 93030, 93031,

PERS Gold PPO Service Area

	93032, 93033, 93034, 93035, 93036, 93040, 93041, 93042, 93043, 93044, 93060, 93061, 93062, 93063, 93064, 93065, 93066, 93094, 93099, 93252
Yolo	95605, 95606, 95607, 95612, 95615, 95616, 95617, 95618, 95620, 95627, 95637, 95645, 95653, 95679, 95691, 95694, 95695, 95697, 95698, 95776, 95798, 95799, 95912, 95937
Yuba	95692, 95901, 95903, 95914, 95918, 95919, 95922, 95925, 95930, 95935, 95941, 95960, 95961, 95962, 95966, 95972, 95977, 95981

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007

El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiijį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。
無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Notes

This Benefit Booklet should be retained for your future reference as a Member of this PPO plan.

Should you have any questions, please call Included Health at 855-633-4436.

PERS *Gold*

Health Plan Research and Administration Division
Self-Funded Health Plans
California Public Employees' Retirement System

PER-0125-GOLD