Evidence of Coverage

Effective January 1, 2027 – December 31, 2027

PERS *Platinum*

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 CVS Caremark 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 Platinum 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 Maximum Calendar Year Coinsurance Responsibility for medical expenses will be $10,000 per individual and $20,000 per Family. Your maximum Calendar Year Coinsurance Responsibility will be $2,000 per individual and $4,000 per Family.

Family Building Benefits
Effective July 1, 2027, the Family Building Benefits section is updated to reflect increased coverage for Infertility services.

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 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 Copayments, Deductibles and/or Coinsurance, 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 Copayments, Deductibles and/or Coinsurance 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; for ancillary

services at an in-network facility, your Copayment or Coinsurance will be the same as the amount due to a Preferred Provider at an in-network facility under similar circumstances and you will not be responsible for additional charges above the Allowable Amount. This includes the Professional Services as well as supplies and equipment involved in your ancillary care at the in-network facility. 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 Coinsurance is Calculated

Your Coinsurance 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 amounts 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 Maximum Calendar Year Coinsurance Responsibility.

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 Copayments, Deductibles, and/or Coinsurance for that claim. Your Preferred Provider Copayments, Deductibles and/or Coinsurance 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:

Consolidated Appropriations Act of 2021 (CAA)

- 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, https://blueshieldca.com/, to the following information:

- Preferred Provider negotiated Rates; and

- Historical Non-Preferred Provider Rates.

Your Introduction to the PERS Platinum 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 Choosing Your Provider 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.

CVS Caremark provides Prescription Drug benefit management services for PERS Platinum. These services include administration of the Retail Pharmacy Program and the Mail Service Pharmacy 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 Platinum, 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 Platinum 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 Platinum!

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.

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

Contact Information

MEMBER SERVICES
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
or message the team using the Included Health mobile app.
Toll-free text telephone (TTY): 711

Blue Shield portal:
https://blueshieldca.com/

24/7 NURSE LINE
Registered nurses are available to answer your medical questions 24 hours a day, seven days a week. You can reach a specially trained registered nurse who can address your health care questions by calling:
Included Health
855-633-4436
Be prepared to provide your name, the patient's name (if you're not calling for yourself), the identification number, and the patient's phone number.

UTILIZATION REVIEW SERVICES
For questions about prior authorization for hospitalizations and specified services, call:
Included Health
855-633-4436

Evolent (for outpatient radiological services)
888-642-2583

Evolent (for oncology services)
888-999-7713

For Claims -please mail your correspondence and medical claims for services by Non-Preferred Providers to:
Blue Shield of California
P.O. Box 272530
Chico, CA 95927

PRESCRIPTION DRUG PROGRAM
For information regarding the Retail Pharmacy Program or Mail Service Pharmacy Program, call or visit on-line:
CVS Caremark 1-833-291-3649
(TTY users call 711)
https://caremark.com/calpers

ELIGIBILITY AND ENROLLMENT
For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the California Public Employees' Retirement System (CalPERS) Health Account Management Division (retirees). You also may write:
Health Account Management Division
CalPERS P.O. Box 942715
Sacramento, CA 94229-2715

Or call: 888 CalPERS (or 888-225-7377) (916) 795-3240 (TDD)

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

CALPERS PPO WEBSITE:
Visit our site at:
https://includedhealth.com/microsite/calpers/

PERS Platinum Summary of Benefits

The following is only a Summary of Benefits under your PERS Platinum 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 Medical and Hospital Benefits 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 Benefit Limitations, Exceptions and Exclusions 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 Platinum 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: $2,000

For each Family:
Preferred Providers: $1,000
Non-Preferred Providers: $4,000

(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: $2,000
For each Family: $4,000

Monthly Rates

State Employees and Annuitants

The Rates shown below are effective January 1, 2027 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	$1,623.10
Employee and one dependent	$3,246.20
Employee and two or more dependents	$4,220.06

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, 2027 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	$1,778.62
Region 2	$1,538.57
Region 3	$1,549.00
Region 4	$1,507.81
Employee and one dependent	
Region 1	$3,557.24
Region 2	$3,077.14
Region 3	$3,098.00
Region 4	$3,015.62
Employee and two or more dependents	
Region 1	$4,624.41
Region 2	$4,000.28
Region 3	$4,027.40
Region 4	$3,920.31

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

[4] Out-of-California: all other states.

Rate Change

The plan Rates may be changed as of January 1, 2028, following at least 60 days' written notice to the Board prior to such change.

PERS Platinum Identification Card

Following enrollment in PERS Platinum, you will receive a PERS Platinum 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. The ID Card includes the following information: member name, member ID, Group #, health plan and network names, medical copays and deductibles, medical insurance contact information and pharmacy benefits information. If you need a replacement card or a card for a Family Member, contact Included Health at 855-633-4436.

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. The Included Health app also has the information that is on the ID Card in the "Insurance Information" section on the "Me" page.

Possession of a PERS Platinum 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.

Choosing Your Provider

Preferred Providers

The PERS Platinum 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 contracted with Blue Shield of California and offer advantages like lower copayments and greater savings when used as they are in-network. **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, log in to your Included Health account at includedhealth.com/calpers. Click on "view more services" and access your Blue Shield of California member account for submitting claims or appeals. **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.

If you Cannot Find a Preferred Provider

Call Included Health if you need help finding a Preferred Provider who can provide the care you need close to home. If a Preferred Provider is not available, you can ask for an authorized referral to see a Non-Preferred Provider at the Preferred Provider Copayment or Coinsurance. If we determine the services cannot reasonably be obtained from a Preferred Provider, Blue Shield of California will approve your request and you will only be responsible for the Preferred Provider Copayment or Coinsurance plus any charges in excess of the Allowable Amount and all charges for non-covered services.

Selecting Your Primary Care Physician

The Plan allows you to select a Primary Care Physician (PCP). You may select any PCP who participates in the Preferred Provider network and is available to accept you or your family members. The selected PCP will be added to your ID card after the plan is notified. However, you do not need to visit your PCP or get a referral from your PCP before you receive care from another provider. We encourage you to select a PCP at the time of enrollment. If a PCP is not selected, the Plan will match you to one. If you are matched with a PCP by the Plan it will remain in effect until you notify the plan of your selection. You have the ability to change your PCP at any time. To change your matched PCP, visit https://blueshieldca.com/, use the Included Health app or log in to your account by visiting includedhealth.com/calpers.

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

It is recommended you choose a PCP that is located close to your home or work location to ensure access to care. Your PCP is your first point of contact when you need Covered Services. Your Chosen PCP can provide primary care and help direct you to specialized care.

PCPs may be:

- General practitioners;
- Family practitioners;
- Internists;

- Obstetrician/gynecologists; or
- Pediatricians.

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.

Accessing Care

Emergency Services

If you need emergency care, call your Physician or go to the nearest Facility that can provide emergency care. Each time you visit a Hospital's emergency room for Emergency Care Services you will be responsible for paying a separate $50 Emergency Room Copayment that will be subtracted from your covered charges. However, this Copayment will not apply if you are admitted to a Hospital either for Outpatient medical observation or on an Inpatient basis immediately following emergency room treatment. This Copayment does not apply to the Calendar Year Deductible. However, it does apply to the Maximum Calendar Year Medical Financial Responsibility.

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. For a complete description of the Emergency Care Benefit and applicable Copayments, see Emergency Care in the Medical and Hospital Benefits section.

Non-Emergency Services

Before receiving non-emergency services, be sure to discuss the services and treatment thoroughly with your Physician and Other Provider(s) to ensure that you understand the services you are going to receive. Refer to the Medical and Hospital Benefits section and the Benefit Limitations, Exceptions and Exclusions section.

If prior authorization is required, remember to call Included Health before services are provided to avoid increased Coinsurance responsibility.

Urgent Care Services

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. Urgent care centers are for non-life-threatening injuries and illnesses that are more time-sensitive or require more prompt attention than a routine office visit.

Medical Services

If you need health care services, your Copayment or Coinsurance responsibility will be lower if you choose a Preferred Provider. To ensure services are covered refer to the Medical and Hospital Benefits section on page 37.

Prior Authorizations

Some services (procedures or medical equipment) require a prior authorization be submitted and approved prior to services or equipment dispersion. 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 Copayment or Coinsurance.

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. See page 81 in the General Provisions section for a list of services and more information.

Accessing Care

Included Health Services

Included Health is your member services, and they have a number of additional services available to you through your plan. In this section you will find all member services available to you provided by Include Health.

Expert Medical 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, to help Members understand their options.

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.

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 Platinum 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. 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.

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 understand and manage specific acute and chronic health conditions such as asthma, diabetes, heart disease, and autoimmune conditions like multiple sclerosis.

- Case Management: Offers comprehensive support services to help Members navigate acute medical events, such as surgeries and hospitalizations.

- 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.

Your program may include:

- Mailing of educational materials outlining steps you can take to improve your health; and/or
- Phone calls from a nurse, primary care physician or specialists to coach you through self-management of your condition and to answer questions —whether virtual or in-person.
- Custom care plan for your specific health condition(s).
- 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.

Accessing Care

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

CVS Caremark Medication Adherence Program

Adherence to Medication therapy is vital for treatment if you have a chronic condition or disease. CVS Caremark will reach out to you, your Physician and/or pharmacists to help manage your medical condition. If a Prescription has not been refilled, CVS Caremark may contact you and your Physician by phone, letter or fax. CVS Caremark may also work with you and your local pharmacist to dispense the needed Prescription.

CVS Caremark pharmacists are available 24 hours a day to answer any Medication questions you may have. They strive to make adherence as easy as possible for you by providing frequent reminders through phone calls, text messaging and information provided on the Member website.

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.

If you live or work in one of the ZIP codes listed below, you are considered to be outside the Plan service area ("Out-of-Area"). Out-of-Area medical and Hospital services, including services received in a foreign country for urgent or emergent care, are reimbursed at the Preferred Provider level, based on the Allowable Amount.

When a Preferred Provider is not available, you can obtain an exception to see a Non-Preferred Provider at the Preferred Provider Copayment or Coinsurance. Visit includedhealth.com/calpers or call Included Health at 855-633-4436 for an exception attestation form. Your form must be submitted at least 5 days prior to services being rendered. Please email your completed form to calpersclaims@blueshieldca.com or mail your completed form to:

Blue Shield of California
P.O. Box 272530
Chico, CA 95927

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 by a Non-Preferred Provider, Benefits will be reimbursed at the Non-Preferred Provider level.

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

Although there are Preferred Providers available in 41 Blue Cross and/or Blue Shield Plans across the country, there are a few areas in the United States that do not have Preferred Providers located within a Plan service area. Members in those areas shall be considered "Out-of-Area."

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, use the Included Health app.

A fee may apply for late cancellations or missed appointments for virtual urgent care, virtual primary care, virtual therapy, or virtual psychiatry visits (collectively referred to as "virtual care" services). The cancellation fee for scheduled Physician visits is $30. The cancellation fee for behavioral health visits is the total contracted visit fee depending on the specific type of visit. Please contact Included Health for more information on applicable cancellation fees.

Overview

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as Inter-Plan Programs. These Inter-Plan Programs operate under 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 Programs.

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 generally obtain care from preferred providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may receive care from non-preferred providers that do not have a contractual agreement with the Host Blue. PERS Platinum Basic payment practices in both instances are described in this section.

Inter-Plan Programs

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 access Covered Services within the geographic area served by a Host Blue, PERS Platinum will remain responsible for the benefits and provisions of this Plan. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with preferred providers and 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 Platinum.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your provider. Sometimes, it is an estimated price that considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also consider adjustments to correct for over or underestimation of modifications of past pricing as noted above. However, such adjustments will not affect the price PERS Platinum 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 be based on either the Host Blue's non-preferred healthcare provider local payment, the Allowable Amount PERS Platinum 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 Platinum will make for Covered Services as described in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

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 Coinsurance 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 benefit description.

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.

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

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 272530, 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 272530, 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.

Medical Necessity

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 Platinum 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.

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.

Medical Necessity

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 health care service plan and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.

Paying for Covered Services

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Services before the Plan begins payment.

Charges incurred while covered by any other CalPERS-sponsored health benefits plan for services received prior to the effective date of enrollment in PERS Platinum are not transferable to PERS Platinum, and Deductibles under any other such plan will not apply toward the Calendar Year Deductible for PERS Platinum. 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 for each Plan Member, and $1,000 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 $2,000 for each Plan Member and $4,000 per Family. The Non-Preferred Provider Calendar Year Deductible does not apply towards the Maximum Calendar Year Medical Financial Responsibility.

Charges will be applied to the Deductible beginning on January 1, 2027, and will extend through December 31, 2027. 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 following Covered Services do NOT apply to the Calendar Year Deductible:

- Physician office, Retail Health Clinic Office Visit, Outpatient Hospital and Urgent Care visits and consultations provided by Preferred Providers.
- Diabetes self-management education program services received from Preferred Providers.
- Immunizations received from Preferred Providers.
- Preventive Health Services received from Preferred Providers.
- Abortion Services.
- Doula Services.
- 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.

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 two thousand dollars ($2,000) per Member, not to exceed four thousand dollars ($4,000) 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 Maximum Calendar Year Coinsurance Responsibility:

- 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.

Maximum Calendar Year Medical Financial Responsibility

There is a Maximum Calendar Year Financial Responsibility broken down into a maximum medical responsibility and maximum Pharmacy responsibility. The maximum medical responsibility ($10,000per Member and $20,000 per family), in general, is accumulated by the Calendar Year Deductible, Coinsurance, and Copayments, for services provided by Preferred Providers. The maximum Pharmacy responsibility ($2,000 per Member and $4,000 per family) is accumulated by covered Prescription Copayments.

Maximum Calendar Year Pharmacy Financial Responsibility

When you receive covered Prescription services, your Copayments are applied toward the Maximum Calendar Year Pharmacy Financial Responsibility of $2,000 per Plan Member, and $4,000 per Family. Once you incur expenses equal to those amounts, you will no longer be required to pay an additional Copayment for the remainder of that Calendar Year. Within and as a subset of this maximum, there is a maintenance medication program, CVS Caremark Mail Service Pharmacy (Generic and Preferred Brands) and Specialty Mail Copayment limit of $1,000. Once you incur expenses equal to $1,000 per Plan Member, you will no longer be required to pay any additional Copayment for covered Prescription services received through CVS Caremark Mail Service Pharmacy for the remainder of that Calendar Year. 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.

Erectile or Sexual Dysfunction Drug Coinsurance and Member Pays the Difference Copayments DO NOT APPLY to the Maximum Calendar Year Pharmacy Financial Responsibility.

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 Copayment or Coinsurance.

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 Copayment or Coinsurance.

Generally, the Plan will pay its portion of the Allowable Amount and you will pay your Copayment or Coinsurance. 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 Copayment or Coinsurance 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 Copayment or Coinsurance; 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.

Paying for Covered Services

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 Copayment or Coinsurance 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.

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 Platinum uses claims information to track dollar amounts that count toward your Deductible and Maximum Calendar Year Coinsurance Responsibility.

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 272530
Chico, CA 95927
Online at: includedhealth.com/calpers

Each claims submission must contain the following:

- Subscriber's name
- Subscriber ID / Member number
- Group number
- Patient's name
- Patient's date of birth
- Patient's date of injury/illness or onset of illness or pregnancy
- Date(s) of service
- Diagnosis
- Type(s) of service
- Provider's name & tax ID number
- Amount charged for each service
- Patient's other insurance information
- For Members with Medicare — the Medicare ID number and the Medicare effective date

Paying for Covered Services

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

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 Copayment or Coinsurance and the payment made by PERS Platinum 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.

Plan Payment and Member Copayment and Coinsurance Responsibility

Disclosure of Allowable Amount

You may call Included Health at 855-633-4436 and ask to be provided with information on how much the Plan will pay for certain planned procedures to be performed by a Non-Preferred Provider. In order for you to obtain this information, you must request that Included Health send a Disclosure of Allowable Amount form to your Non-Preferred Provider. Your Non-Preferred Provider will need to fill out the required information on the form (e.g., letter requesting the dates, specific procedure code numbers, and projected dollar amounts for the proposed). After receiving the completed form from your Non-Preferred Provider, the Allowable Amounts will be determined, and a copy of this information will be sent to you and your Non-Preferred Provider.

Disclosure of Allowable Amount estimates are only valid for 30 days. If your request is received more than 30 days prior to commencement of services, it cannot be processed. Any charges your Non-Preferred Provider may require for the completion of this form are not a covered benefit of this Plan. **Disclosure of Allowable Amount estimates are provided for informational purposes and are not a guarantee of payment.**

The following example shows the financial consequences of not choosing care through a Preferred Provider. The amount a Member pays is significantly more if care is received through a Non-Preferred Provider. The example below is illustrative only and is not actual claimant information. Also, though this example does not include Copayments, many actual covered services under the Plan have Copayments.

Plan Payment and Member Copayment and Coinsurance Responsibility

Example of an inpatient facility charge for a Member:

	Preferred Provider	Non-Preferred Provider
Billed Charge	$300,000	$300,000
Allowable Amount	$130,000	$130,000
Calendar Year Deductible & Hospital Admission Copayment	$500 + $250	$2,000 + $250
Coinsurance	$3,000	$51,100; Member is responsible for paying 40% of the remaining Allowable Amount after the Deductible which would be $127,500
Plan Payment	$126,000	$76,500; Plan is responsible for 60% of the remaining Allowable Amount of $127,500
Remaining Balance	$0	$170,000 Non-Preferred Provider can bill the Member for the difference between Allowable Amount and Billed Charges
Total Amount the Member Is Responsible To Pay	$3,750	$223,600

Preferred Providers have agreed to accept the Plan's payment, plus applicable Member Deductibles and Copayments or Coinsurance, as payment in full for Covered Services. Plan Members are not responsible to pay Preferred Providers for any amounts above Blue Shield of California's Allowable Amount, whichever applies within a provider's geographic service area. After a Member meets their Calendar Year Deductible and the maximum Copayment or Coinsurance responsibility during a Calendar Year, the Plan will pay 100% of the Allowable Amount, up to any applicable medical benefit maximums, for covered services and supplies provided by Preferred Providers for that Member for the remainder of that year.

Non-Preferred Providers do not participate in Blue Shield of California Preferred Provider network. Non-Preferred Providers have not agreed to accept the Plan's payment, plus applicable Member Deductibles and Coinsurance as payment in full for Covered Services. The Allowable Amount for Covered Services provided by Non-Preferred Providers is usually lower than what they customarily charge. After a Member meets their Calendar Year Deductible, the Plan will pay 60% of Allowable Amount. Non-Preferred Providers may bill the Member for the difference between the Allowable Amount and the Non-Preferred Provider's Billed Charges in addition to applicable Member Deductibles, Coinsurance and amounts in excess of specified Plan maximums.

After the Calendar Year and any other applicable Deductible has been satisfied, reimbursement for Covered Services will be provided as described in this section.

Physician Services

Plan Payment and Member Copayment and Coinsurance Responsibility

1. Non-Emergency Care Services

a. Members Who Reside Within Area

i. When Accessing Preferred Providers:

Physician office visits, Physician office visits in Retail Health Clinic, Physician Outpatient Hospital visits and Physician Outpatient Urgent Care visits by a Preferred Provider are paid at Blue Shield of California Allowable Amount less the Member's $20 or $35 Copayment. The $20 or $35 Copayment will also apply to Physician or Health Professional visits for diabetes self-management education. Note: This Copayment applies to the charge for the Physician visit only. Other Covered Services provided by a Preferred Provider are paid at 90% of the Allowable Amount, except for services with a $20 or $35 Copayment. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician. Plan Members are responsible for the remaining 10% and any charges for non-covered services if provided by a Preferred Provider. Preventive Health Services received from a Preferred Provider are paid at 100% of the Allowable Amount when billed with a routine or preventive care diagnosis.

NOTE: Members who reside within a Preferred Provider area and receive services from a Non-Preferred Provider will be reimbursed at the Non-Preferred Provider level as stated below in (ii).

ii. When Accessing Non-Preferred Providers:

Covered services provided by a Non-Preferred Provider are paid at 60% of the Allowable Amount. Plan Members are responsible for the remaining 40% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.

NOTE: Regardless of the reason (medical or otherwise), referrals by Preferred Providers to Non-Preferred Providers will be reimbursed at the Non-Preferred Provider level.

iii. When Accessing a Non-Preferred Provider Because a Preferred Provider is not Available:

Covered Services provided by a Non-Preferred Provider (other than for Emergency Care Services) are automatically paid at 60% of the Allowable Amount. If a Preferred Provider is not available within a 50-mile radius of your residence or work, you may receive Covered Services from a Non-Preferred Provider at 90% of the Allowable Amount **only if authorization is obtained before the services are rendered. You are responsible for the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services.**

If an authorized referral is NOT obtained prior to services being provided, your claim will automatically be paid at 60% of the Allowable Amount. Upon receipt of your Explanation of Benefits (EOB), contact Member Services to request that your claim be reprocessed at the 90% level. You are responsible for the remaining 10% and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

To ensure that your claims will be paid at the 90% level, you should obtain an authorized referral BEFORE services are provided. To obtain an authorized referral, you or your Physician must call Member Services at 855-633-4436 at least 5 business days prior to scheduling an admission to, or receiving the services of, a Non-Preferred Provider.

b. Members Who Reside Out-of-Area

(Refer to the list of qualifying ZIP Codes)

Physician office visits, Physician office visits in Retail Health Clinic, Physician Outpatient Hospital visits and Physician Outpatient Urgent Care visits are paid at the Allowable Amount less the Member's $10 or $35 Copayment. Members are responsible for the $20 or $35 Copayment, any charges in excess of the Allowable Amount, and all non-covered charges. The $20 or $35 Copayment will also apply to Physician or Health Professional visits for diabetes self-management education. Note: This Copayment applies to the charge for the Physician visit only.

Other Covered Services are paid at 90% of the Allowable Amount. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician. Members are responsible for the remaining 10%, any charges in excess of the Allowable Amount, and all non-covered charges.

Preventive Health Services are paid at 100% of the Allowable Amount when billed with a routine or preventive care diagnosis. Members are responsible for any charges in excess of the Allowable Amount and all non-covered charges.

2. Emergency Care Services

Physician services for emergency care provided by Preferred and Non-Preferred Providers are paid at 90% of the Allowable Amount. Members are responsible for the remaining 10%. In addition, when services are provided by a Non-Preferred Provider, Members are also responsible for all charges in excess of the Allowable Amount plus all charges for non-covered services. Some emergency room Physicians are Non-Preferred Providers at Preferred Hospitals. For services to be covered under the emergency care services benefit, they must be billed with an emergency code.

Hospital Services

1. Non-Emergency Care Services

a. Members Who Reside Within Area

i. When Accessing Preferred Hospitals:

Covered services provided by a Preferred Hospital or Ambulatory Surgery Center are paid at 90% of the Allowable Amount for covered services. Plan Members are responsible for the remaining 10% of the lesser of Billed Charges or the Allowable Amount for Covered Services and all charges for non-covered services.

NOTE: Members who reside within a Preferred Provider area and receive services from a Non-Preferred Provider will be reimbursed at the Non-Preferred Provider level as stated below in (ii). **Individual Providers at Preferred Hospitals may not be Preferred Providers.**

ii. When Accessing Non-Preferred Hospitals:

Covered services provided by a Non-Preferred Hospital are paid at 60% of Reasonable Charges. Plan Members are responsible for the remaining 40%, the amount billed over any Reasonable Charges, and all charges for non-covered services.

iii. Services Received from Non-Preferred Providers while receiving care at a Preferred Hospital:

Covered services provided by Non-Preferred Providers who are part of the Preferred Hospital or Outpatient Hospital Setting staff are paid at 90% of the Allowable Amount.* **Plan Members are responsible for the remaining 10%.** For example, you may be admitted to a Preferred Hospital or Outpatient Hospital Setting and some Physicians, such

as anesthesiologists, radiologists and pathologists, on the hospital's staff are Non-Preferred Providers.

If you receive services from a Non-Preferred Provider, such as an admitting Physician, surgeon, or assistant surgeon, whose charges are billed separately from the Hospital or Outpatient Hospital Setting facility charges, and the provider gives you notice of those charges and you consent to receive the services, the Plan pays 60% of the Allowable Amount. You are responsible for the remaining 40% of the Allowable Amount and any amount charged above the Allowable Amount, in addition to any charges for noncovered services.

*Although benefits are provided at the higher reimbursement level, it is still in your best financial interest to verify that all health care providers treating you are Preferred Providers. Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting.

b. Members Who Reside Out-of-Area

(Refer to the list of qualifying ZIP Codes)

Covered Services provided to Plan Members who reside Out-of-Area are paid at 90% of Reasonable Charges. Members are responsible for the remaining 10% and all charges for non-covered services.

2. Emergency Care Services

Covered Services provided by a Preferred Hospital that are incident to emergency care are paid at 90% of Billed Charges or 90% of the Negotiated Amount, whichever is less. Covered Services provided by a Non-Preferred Hospital that are incident to emergency care are paid at 90% of Reasonable Charges. For both Preferred Hospitals and Non-Preferred Hospitals, Plan Members are responsible for the remaining 10% and all charges for non-covered services. In addition, at Non-Preferred Hospitals, Members are responsible for all charges in excess of the Reasonable Charges.

Emergency room facility charges for non-Emergency Care Services are the Plan Member's responsibility. If your emergency room charges are rejected under this Plan because it is determined that they were for non-emergency care and you feel that your condition required Emergency Care Services, you should contact Blue Shield of California and request a reconsideration. **Emergency Care Services** are those services required for the alleviation of the sudden onset of severe pain, or a Psychiatric Emergency Medical Condition, or the immediate diagnosis and treatment of an unforeseen illness or injury which could lead to further significant Disability or death, or which would so appear to a layperson. For more information, please see the Medical Claims Review And Appeals Process section.

NOTE: If a Member is a patient in a Non-Preferred Hospital, Emergency Care Services benefits shall be payable until the patient's medical condition permits transfer or travel to a Preferred Hospital. If the patient elects not to transfer or travel to a Preferred Hospital once his or her medical condition permits, reimbursement will be reduced to the 60% level and paid as stated in 1b. Payment to a Hospital will be reduced if utilization review requirements are not met.

Medical and Hospital Benefits

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 all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the Benefit descriptions below, and to the Benefit Limitations, Exceptions and Exclusions 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.

Covered Services provided under this Plan are payable only when Medically Necessary in accordance with Blue Shield's medical policy.

Acupuncture

$15 Copayment Preferred Provider
60% Non-Preferred Provider

Coverage for acupuncture services provided by a Physician or Health Professional to treat a disease, illness or injury, includes a patient history visit, physical examination, treatment planning and evaluation, electro-acupuncture, cupping and moxibustion.

Acupuncture and chiropractic care services are limited to a combined maximum of 20 visits per Calendar Year. See the Chiropractic Benefit description.

Allergy Testing and Treatment

90% 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.

Alternative Birthing Center

90% Preferred Provider or Non-Preferred Provider

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 90% 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.

Ambulance

90% Preferred Provider or Non-Preferred Provider (based on contracted rate or billed charges, whichever is less)

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.

Ambulatory Surgery Centers

100% Preventive care (Preferred Provider and Out-of-Area)
90% Preferred Provider, Diagnostic colonoscopy services and Out-of-Area
60% Non-Preferred Provider

Ambulatory Surgery Center services are subject to the Maximum Calendar Year Coinsurance Responsibility, except for Preventive Health Services.

Services received from Non-Preferred Ambulatory Surgery Centers have no Coinsurance limits for facility charges and have higher out-of-pocket costs.

Preferred Ambulatory Surgery Centers:
Covered Services and supplies provided and billed by a Preferred Ambulatory Surgery Center are paid at 90% of the Allowable Amount. You are responsible for the remaining 10% of the Allowable Amount and all charges for non-covered services.

Physician Services Billed Separately From Facility Charges
The Ambulatory Surgery Center facility benefit applies only to facility charges.

Physician services related to your procedure, such as services provided by a surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, or other Physician, may be billed separately from the Ambulatory Surgery Center facility charges. These services are covered under the applicable Physician Services Benefit and are **not** subject to the Ambulatory Surgery Center facility maximum.

Preferred Physicians
Covered Services provided by a Preferred Physician whose services are billed separately from the facility charges are paid according to the applicable Preferred Provider Physician Services Benefit. You are responsible for the applicable Preferred Provider cost-sharing amounts and all charges for non-covered services.

Non-Preferred Facility-Based Providers

Covered Services provided by Non-Preferred Providers who are part of the Ambulatory Surgery Center staff, including anesthesiologists, radiologists, pathologists, and other facility-based providers assigned by the Ambulatory Surgery Center, are paid at 90% of the Allowable Amount. You are responsible for the remaining 10% of the Allowable Amount, , and charges for non-covered services.

Non-Preferred Ambulatory Surgery Centers
Covered Services and supplies provided and billed by a Non-Preferred Ambulatory Surgery Center are subject to **a maximum Plan payment of $350 per outpatient surgery, which results in higher out-of-pocket cost to you.**

This maximum payment applies only to facility charges billed by the Non-Preferred Ambulatory Surgery Center.

This maximum payment does not apply to physician services billed separately from the facility charges.

Physician services billed separately from the facility charges are reimbursed according to the applicable Preferred Provider or Non-Preferred Provider Physician Services Benefit.

You will be responsible for the remaining 40% of the Allowable Amount, any charges above the Allowable Amount, and charges for non-covered services.

The following procedures are generally considered routine services and can be safely performed at an Ambulatory Surgery Center:

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

Choosing the Most Cost-Effective Site of Care

The highest level of benefits and lowest out-of-pocket costs are when these procedures are performed at a Preferred Ambulatory Surgery Center by Preferred Providers.

If these procedures are performed at a Non-Preferred Ambulatory Surgery Center, higher Member cost-sharing and additional financial liability may apply.

Before scheduling a procedure:

- Verify that the Ambulatory Surgery Center is a Preferred Provider.
- Verify that their surgeon and other treating providers are Preferred Providers whenever possible.
- Contact Included Health for assistance identifying Preferred Providers and Preferred Ambulatory Surgery Centers.

If you have one of these procedures in an Outpatient Hospital facility instead of a Preferred Ambulatory Surgery Center, you will have to pay the difference between what your health plan covers and the Hospital's charges, which could be a significant cost to you. 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 services that require approval before treatment. Prior authorization is required for many non-emergency procedures, services, and surgeries, including certain inpatient

and imaging services. Non-emergency services generally require prior authorization 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.

Autism Spectrum Disorder

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

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 90% of the Allowable Amount.

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.

Applied Behavior Analysis (ABA) prescribed by a Physician or licensed psychologist and provided under a treatment plan to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism is administered by Blue Shield of California. For more information, call Included Health at 855-633-4436. For services that require prior authorization, your provider should call 800-541-6652. Visit includedhealth.com/calpers to find a Preferred Provider in-network.

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 Behavior 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.

Bariatric Surgery

90% at Blue Distinction Centers for Specialty Care
90% 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 5 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 10% 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.

Breast Feeding

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

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

Cardiac Care

Hospital Services	**90% Preferred Provider** **60% Non-Preferred Provider**
Evaluations and Diagnostic Tests	**90% Preferred Provider** **60% Non-Preferred Provider**

All non-emergency hospitalizations require prior authorization as soon as possible, but no later than 5 business days prior to the commencement of services.

Hospital and professional services provided in connection with cardiac care are a benefit only to the extent that the services are Medically Necessary and medically appropriate for the patient. Cardiac care does not include heart transplants (see Transplant benefits on page 68) nor services for Outpatient cardiac Rehabilitation (see Outpatient or Out-of-Hospital Therapies on page 61).

Childbirth Classes

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

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).

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

Chiropractic

$15 Copayment Preferred Provider
60% Non-Preferred Provider

Chiropractic care is covered for the treatment of illness or injury. Services include, but are not limited to, manipulation of the spine, joints and/or musculoskeletal soft tissue, re-evaluation, and/or other services.

Acupuncture and chiropractic care services are limited to a combined maximum of 20 visits per Calendar Year. (See the Acupuncture Benefit description).

Christian Science Treatment

90% Preferred Provider or Non-Preferred Provider. Benefits are limited to 24 sessions per person per Calendar Year.

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.

Clinical Trials

90% Preferred Provider
60% Non-Preferred Provider

Routine patient costs, as described below, for an approved clinical trial

Coverage is provided for services you receive as a qualified enrollee in an approved clinical trial. The services must be those that are listed as covered by this Plan. A "qualified enrollee" means that you meet the following conditions.

1. Your Physician gets prior authorization for the Clinical Trial from this plan; and

2. 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

3. 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.

Colonoscopy Services

100% Preventive Care, Preferred Provider and Out-of-Area
90% Diagnostic Care, Preferred Provider and Out-of-Area
60% Non-Preferred Provider

A **colonoscopy** may be covered as either preventive care or diagnostic care, depending on the reason for the procedure and how the services are billed.

1. Physician Services

Preventive Care
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.

For purposes of this Benefit, "preventive care" means Physician 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
Diagnostic colonoscopy services are subject to the applicable Deductible, Copayment, Coinsurance, and Maximum Calendar Year Medical Financial Responsibility limits under the Plan.

Diagnostic care means Physician visits and medical services related to a colonoscopy when billed with a diagnostic care diagnosis code. These services can include colonoscopy to evaluate symptoms, investigate abnormal findings, monitor a medical condition, or provide follow-up care after treatment. For example:
- Follow-up colonoscopy after abnormal results or cancer treatment.

2. Anesthesia Services

Intravenous Conscious Sedation
There is no Deductible, Copayment, or Coinsurance for Medically Necessary intravenous conscious sedation provided by a Preferred Provider during 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 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.

3. Facility Services

Ambulatory Surgery Centers
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. Procedures performed at a Preferred Ambulatory Surgery Center are covered according to the Plan and are not subject to a site-of-care Benefit maximum. Choosing a Preferred Ambulatory Surgery Center generally provides the highest level of Benefits and lowest out-of-pocket costs. 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
For preventive colonoscopy services received from Preferred Providers, the Calendar Year Deductible does not apply. For diagnostic colonoscopy services, applicable Deductible, Coinsurance, and Maximum Calendar Year Medical Financial Responsibility will apply. Services received from Non-Preferred Providers are not subject to Coinsurance limits.

If a preventive or diagnostic colonoscopy is performed in an Outpatient Hospital setting and an approved exception does not apply, the Plan's maximum payment for the facility portion of the procedure is $1,500 per procedure, whether the colonoscopy is preventive or diagnostic. Charges that exceed the Plan's $1,500 maximum payment are your responsibility and may result in significant out-of-pocket costs.

The $1,500 maximum applies only to Outpatient Hospital facility charges. Physician services, anesthesia services, pathology services, and other separately billed professional services are covered according to the applicable Preferred Provider or Non-Preferred Provider Physician Services Benefit.

Outpatient Hospital Exceptions
An exception may be approved when:

- Your Physician determines that an Outpatient Hospital setting is medically necessary for patient safety; or
- There is no Preferred Ambulatory Surgery Center provider within a 30-mile radius of the Member's home.

Your Physician will need to submit the request on your behalf and provide the clinical documentation required to support Medical Necessity. The exception request should be submitted and approved before services are rendered. If an approved exception is not in place before services are provided, the $1,500 Outpatient Hospital payment maximum will apply.

If you need help determining whether an exception may apply, locating a Preferred Ambulatory Surgery Center, or reviewing a claim after services have been provided, contact Included Health.

Diabetes Care

1. Diabetic Equipment

90% 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

$20 Copayment Preferred Provider (not a Specialist) and Out-of-Area
$35 Copayment, Preferred Provider (Specialist)
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.

3. Diabetes Prevention Program

Blue Shield of California offers a Diabetes Prevention Program (DPP), which is designed to slow and prevent type 2 diabetes among Members who have prediabetes - a condition in which a person's blood sugar level is higher than normal, but not yet high enough for the individual to be considered diabetic. The DPP curriculum promotes realistic lifestyle changes, emphasizing weight loss through exercise, healthy eating, and behavior modification. Sessions are led by trained lifestyle coaches who will empower you to take charge of your health and focus on lasting results.

Program benefits include:

- Improved nutrition
- Increased physical activity
- Motivation to sustain behavior changes
- Peer support
- Stress management

The program lasts one year and consists of 16 sessions over the first six months and at least one session a month for the next six months. You can choose in-person, online, or a combination of both types of sessions.

Diagnostic /Laboratory Services

100% Quest Diagnostics and Labcorp facilities
90% 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 the Maternity Care Benefit for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

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 access 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 access Find a Lab Near You. Labcorp website:

labcorp.com

If you live within the PERS Platinum 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.

Durable Medical Equipment

90% 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. The list of specific Durable Medical Equipment subject to prior authorization is reviewed regularly by Blue Shield to keep pace with advances in medicine and technology, as well as updated for standards of care.

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 the Diabetes Care Benefit 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 The Hospice Care Benefit.

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 covered at 90% from a Preferred or Non-Preferred Provider and limited to one Prosthetic each year up to a maximum payment of $350 per Member.

c. Benefits do not include wigs for any reason, self-help/educational devices or any type of speech or language assistance devices, except as specifically provided above. See the Benefit Limitations, Exceptions and Exclusions 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 the Reconstructive Surgery Benefit. 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 the Diabetes Care Benefit for devices, equipment and supplies for the management and treatment of diabetes.

Emergency Care

90% All Providers

There is a $50 Copayment per visit in the emergency room. If admitted to the Hospital or on an Inpatient basis, the emergency room Copayment 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 Maximum Medical Financial Responsibility.

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 Care Benefit, they must be billed with an emergency code.

Benefits are also provided for emergency maternity admissions if due to unexpected "premature" delivery. A premature delivery is one that occurs prior to the 8th month of pregnancy.

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.

If a patient is in a Non-Preferred Provider Hospital, Emergency Care Services benefits shall be payable until the patient's medical condition permits transfer or travel to a Preferred Provider Hospital. If the patient does not wish to transfer to a Preferred Provider Hospital, reimbursement shall be payable at the Non-Preferred Provider level for all subsequent charges.

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

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 Platinum shall pay the medical transportation provider directly.

Health Care Treatment Following Rape or Sexual Assault

Emergency services and follow-up health care treatment are covered following a rape or sexual assault for the first nine months after Member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

Cost to Member: No charge

Family Building Benefits

Effective January 1, 2027- June 30, 2027:

50% Preferred Provider and Out-of-Area
50% Non-Preferred Provider

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.

Effective July 1, 2027- December 31, 2027:

$35 per treatment bundle, Preferred Provider
Non-Preferred Providers are excluded

The diagnosis and treatment of Infertility. For purposes of this section, "Infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis before the 12-month or 6-month period to establish infertility in paragraph (3).

(2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Includes: Professional, hospital, ambulatory surgery center, ancillary services and drugs administered to diagnose and treat the infertility. Includes coverage for medically necessary expenses for standard fertility preservation services, including sperm, oocyte, and embryo cryopreservation. Fertility preservation services for iatrogenic infertility are also covered for members undergoing a medically necessary treatment that may directly or indirectly cause iatrogenic infertility.

Cryopreservation has a lifetime limit of 5 years from the time the genetic material is first cryopreserved. Separate cryopreservation time limits may apply for iatrogenic infertility.

Services include up to three (3) completed oocyte retrievals with unlimited embryo transfers in accordance with guidelines of the American Society for Reproductive Medicine (ASRM) and the terms of this Evidence of Coverage.

When a Member utilizes a gestational carrier or surrogate, embryo transfers to the gestational carrier or surrogate shall be treated the same as embryo transfers to the Member for purposes of administering the

three completed oocyte retrieval benefit and shall not reduce, limit, or otherwise adversely affect coverage eligibility.

Services include up to three (3) attempts to collect or retrieve sperm.

Exclusions:

- Reversal of voluntary sterilization.
- Compensation, agency fees, matching fees, or other non-medical expenses associated with a surrogate or gestational carrier arrangement or adoption.
- Legal services related to adoption, surrogacy agreements or parental proceedings.
- Storage fees incurred after the applicable coverage period expires, performed solely for elective or non-medically necessary purposes, replacement, relocation, or transport of cryopreserved material between facilities unless authorized by the Plan, and experimental or investigational preservation techniques for cryopreserved material.
- Non-Preferred Providers are excluded.

Family Planning

90% Preferred Provider
60% Non-Preferred Provider

Your plan covers 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.

Intra-uterine devices (IUDs) and time-released subdermal implants for birth control that are administered in a Physician's office are covered.

Note: For services that meet the "Women's Preventive Services Guidelines" of the Health Resources and Services Administration (HRSA), benefits will be provided under the Preventive Care benefit.

Abortion services are covered for all pregnant persons including, but not limited to, transgender individuals. Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, prior authorization is not required. Covered services are not subject to the Deductible, if applicable, Copayment, and/or Coinsurance. "Abortion" means a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

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.

Hearing Aid Services

90% Preferred Provider or Non-Preferred Provider

Limitations: Maximum payment will not exceed $1,000 per Member for both ears for the hearing aid instrument, and ancillary equipment, one every 36 months

The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. 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.

2. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment.

3. Visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid.

4. 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.

Surgically implanted hearing devices (e.g., cochlear implants and bone-anchored hearing aid) are not covered under this Hearing Aid Services benefit but may be covered under the Plan benefits for Prosthetic Appliances described under the Durable Medical Equipment Benefit description.

Hip and Knee Joint Replacement Surgery

90% Preferred Provider 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 Platinum 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. This Benefit maximum does not apply to Out-of-State Members. Surgeries performed at a non-Value Based Purchasing Design Hospital will be subject to any Hospital charges exceeding the Benefit maximum of $35,000 in addition to Deductible and Coinsurance.

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 5 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 the Travel and Lodging Benefits section for more information.

Home Health Care

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Medically Necessary Skilled Care for continued treatment of an injury or illness furnished by a Home Health Agency is covered if the Member is Homebound, for up to **100 visits per Calendar Year**. Services must be Medically Necessary, ordered by the Personal Physician and authorized. Visit maximum is combined for home health care services and home infusion therapy.

1. Home visits to provide skilled nursing services and other skilled services, up to four visits per day, two hours maximum per visit, are covered when provided by any of the following professional providers:

   a. Registered nurse;

   b. Licensed vocational nurse;

   c. Medical Social Worker; or

   d. Licensed physical therapist, occupational therapist, respiratory therapist, or speech therapist.

2. Certified home health aide- a certified Home Health Aide is covered only if you are also receiving the services of a registered nurse or licensed therapist, and the registered nurse is supervising the services. Up to four hours maximum per visit. A visit of four hours or less is considered one visit. Custodial Care is not covered;

3. 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.

Note:

- Nursing cannot be combined to provide Continuous Nursing Services.

- 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.

- See the Hospice Care Benefit 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 the Diabetes Care Benefit.

Home Infusion Therapy

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Services and medications for this benefit require prior authorization prior to any services or medication rendered.

1. 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. Up to 100 visits per Calendar Year are covered. This is included in the 100 visit limit and not in addition to the home health care visit limit. Skilled nursing visits, including skilled nursing visits in association with Home Infusion Therapy services are included under the Home Health Care benefit. See the Home Health Care benefit description on the previous page. Note: For services related to hemophilia, see item 2. 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).

2. 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 Preferred 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 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 the Emergency Care Benefit.)

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 Preferred 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 Medical and Hospital Benefits 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 Medical and Hospital Benefits section.

Hospice Care

90% Preferred Provider and Non-Preferred Provider

To be eligible for Hospice Care benefits, charges must be incurred during a "benefit period" or period of bereavement which commences while the family unit is covered under PERS Platinum. Such charges must be made by, or under the direction of, a hospice program and incurred for a patient who is terminally ill, for which the prognosis of life expectancy is one year or less, as certified by his or her treating Physician. A benefit period begins on the date that the treating Physician certifies that the patient is terminally ill and ends 90 days after it began or on the date of the patient's death, whichever comes first. If the benefit period ends before the death of the patient, a new benefit period may begin if the treating Physician certifies that the patient is still terminally ill. A period of bereavement begins on the date of the patient's death and ends 90 days after it began even though coverage under PERS Platinum may have ended on the date of death.

Covered Services are provided, under the direction of the treating Physician, as follows:

- Interdisciplinary team care with the development and maintenance of an appropriate plan of care;
- Full-time, part-time or intermittent skilled nursing service provided by a registered nurse or licensed vocational nurse in the home or in a hospice Facility;
- Part-time or intermittent home health services that provide supportive care in the home or in a hospice Facility;
- Homemaking services for the patient at the place of residence;
- Social services and counseling services provided by a qualified social worker;
- Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation;
- Physical Therapy, Occupational Therapy, Speech Therapy, and respiratory therapy provided by a licensed therapist;
- Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member;
- Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition.
- Oxygen and related respiratory therapy supplies;
- Counseling for the patient and family. Family counseling includes no more than 2 visits of bereavement counseling, up to 90 days following the patient's death;
- Up to 5 days of Inpatient Hospital care for the patient (Respite Care);
- Palliative care which is appropriate for the illness. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness.

Medical and Hospital Benefits

Hospital Benefits

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

1. Inpatient Hospital services

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Each time you are admitted to a Hospital on an inpatient basis, you are responsible for paying a separate $250 Copayment per hospital admission. This Copayment does not apply to the Calendar Year Deductible. It does apply to the Out-of-Pocket Maximum.

Medically Necessary accommodations in a semi-private room and all Medically Necessary ancillary services, supplies, blood and blood products, 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.

2. Outpatient Hospital services

90% Preferred Provider and Out-of-Area
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.

Covered Outpatient Hospital services and supplies include outpatient surgery, diagnostic services, therapeutic services, dialysis, chemotherapy, radiation therapy, and/or surgical services performed at a Hospital or Outpatient Facility. All services are subject to Medical Necessity.

Higher Cost may apply for these procedures if performed in an Outpatient Hospital.

Many routine procedures can be safely performed at a Preferred Ambulatory Surgery Center. No Benefit maximum applies to facility charges for the procedures listed below when performed at a Preferred Ambulatory Surgery Center. For the procedures listed below, the highest level of Benefits and lowest out-of-pocket costs are generally available when services are performed by Preferred Providers at a Preferred Ambulatory Surgery Center (see Ambulatory Surgery Centers Benefit).

If one of the procedures listed below is performed in an Outpatient Hospital setting and an approved exception does not apply, the Plan will pay up to the maximum amount shown. You will be responsible for any charges that exceed the Plan's maximum payment amount. As a result, choosing an Outpatient Hospital instead of a Preferred Ambulatory Surgery Center may significantly increase your out-of-pocket costs.

Procedure	Maximum Plan Payment if Performed in an Outpatient Hospital Without an Approved Exception

Colonoscopy	$1,500
Cataract Surgery	$2,000
Arthroscopy	$6,000
Upper Gastrointestinal Endoscopy	$1,500
Upper Gastrointestinal Endoscopy with Biopsy	$2,000
Lithotripsy (fragmenting of kidney stones)	$7,000
Laparoscopic Gall Bladder Removal	$5,000
Hernia Inguinal Repair (Members over age 5, non-laparoscopic)	$4,000
Hysteroscopy Uterine Tissue Sample (with biopsy, with or without dilation and curettage)	$3,500
Esophagoscopy	$2,000
Nasal/Sinus Corrective Surgery (Septoplasty)	$3,500
Nasal/Sinus Submucous Resection of Inferior Turbinate	$3,000
Repair of Laparoscopic Inguinal Hernia	$5,500
Sigmoidoscopy	$1,000
Tonsillectomy and/or Adenoidectomy (Members under age 12)	$3,000

Outpatient Hospital Exceptions
An exception may be approved when:

- Your Physician determines that an Outpatient Hospital setting is necessary for patient safety; or
- There is no Preferred Ambulatory Surgery Center within 30 miles of your residence.

Your Physician may submit the exception request on your behalf and provide the clinical documentation needed to support Medical Necessity for an Outpatient Hospital setting. Exception requests must be approved before services are rendered. If an exception is not approved before services are provided, the applicable Outpatient Hospital payment maximums will apply, and you will be responsible for charges that exceed the Plan's maximum plan amount.

If you need help determining whether an exception may apply, or if you need assistance locating a Preferred Ambulatory Surgery Center, contact Included Health.

If you have already received services and believe one of the exception criteria above applies, contact Included Health for assistance. Included Health can help determine whether additional review of your claim may be appropriate.

To help avoid unexpected costs:

- Review the list of procedures that are generally expected to be performed at a Preferred Ambulatory Surgery Center.
- Verify that the facility is a Preferred Ambulatory Surgery Center whenever possible.
- Verify that your surgeon and other treating providers are Preferred Providers whenever possible.
- Discuss any patient safety concerns with your Physician before scheduling your procedure.
- Contact Included Health for assistance locating Preferred Ambulatory Surgery Centers, verifying provider participation, and understanding your Benefits.

Maternity Care

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

1. **Prenatal and Postnatal Physician Office Visits**

   100% Preventive Health Services from a Preferred Provider
   $35 Copayment, Preferred Provider and Out-of-Area
   60% Non-Preferred Provider

2. **Genetic testing and diagnostic procedures for genetic disorders of the fetus in cases of high-risk pregnancy**

   100% Quest Diagnostics and Labcorp facilities
   90% Preferred Provider and Out-of-Area
   60% Non-Preferred Provider

   See the Diagnostic/Laboratory Services Benefit for more information on coverage of other genetic testing and diagnostic procedures.

3. **Inpatient Hospital and Professional Services**

   90% Preferred Provider and Out-of-Area
   60% Non-Preferred Provider

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

   Each time you are admitted to a Hospital on an inpatient basis, you are responsible for paying a separate $250 Copayment per hospital admission. This Copayment does not apply to the Calendar Year Deductible. It does apply to the Out-of-Pocket Maximum.

   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.

4. Abortion Services

100% Preferred Provider or Non-Preferred Provider

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

5. Doula Services

Reimbursement up to $1100 all Providers

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.

The Plan must provide a minimum of 11 visits (virtual or in-person) 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 855-633-4436 for 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 272530
Chico, CA 95927
Online: includedhealth.com/calpers

Mental Health and Substance Use Disorder Services

1. Inpatient Care

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Each time you are admitted to a Hospital on an inpatient basis, you are responsible for paying a separate $250 Copayment per hospital admission. This Copayment does not apply to the Calendar Year Deductible. It does apply to the Out-of-Pocket Maximum.

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

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.

2. Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

$20 Copayment, Preferred Provider and Out-of-Area
60% Non-Preferred Provider

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.

Benefits are provided for Hospital and Physician services Medically Necessary for short-term medical management of detoxification or withdrawal symptoms. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 90% of the Allowable Amount.

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.

3. Outpatient Care (Facility-Based)

90% Preferred Provider
60% Non-Preferred Provider

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 5 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 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.

Outpatient or Out-of-Hospital Therapies

1. Physical Therapy and Occupational Therapy

90% Preferred Provider and Out-of-Area

60% Non-Preferred Provider
Upon referral by a Physician, Medically Necessary services are covered when rendered by a licensed physical therapist for the treatment of an Acute Condition.

Physical Therapy provided on an Outpatient basis for the treatment of illness or injury includes the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

Occupational Therapy provided on an Outpatient basis when the ability to perform daily life tasks has been lost or reduced, or has not been developed, due to illness or injury. It includes programs which are designed to rehabilitate mentally, physically or emotionally disabled persons. Occupational Therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities. Benefits are limited to no greater than 1 visit per day.

Physical and Occupational Therapy are limited to a combined maximum of 24 visits per Calendar Year and no more than 1 visit per day. The Plan will pay for additional visits during a Calendar Year if you obtain prior authorization and the Plan determines additional visits or subsequent periods of care is Medically Necessary.

2. Cardiac rehabilitation

90% 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.

3. Pulmonary rehabilitation

90% 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 the Home Health Care Benefit for information on coverage for Rehabilitative Care rendered in the home.

4. Speech Therapy

90% Preferred Provider and Out-of-Area
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. The Plan will pay for additional visits during a Calendar Year if you obtain prior authorization. Contact Included Health for more information. 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 the Home Health Care Benefit, no Outpatient Benefits are provided for Speech Therapy, speech correction, or speech pathology services.

See the Home Health Care Benefit for information on coverage for Speech Therapy services rendered in the home. See the Hospital Benefits section for information on Inpatient Benefits and the Hospice Care Benefit for Hospice Program services.

Physician Services

1. Physician Office Visits

$20 Copayment Preferred Provider (not a Specialist) and Out-of-Area
$35 Copayment Preferred Provider (Specialist 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, administration of injectable medications that must be administered by a Health Care Provider, medical nutrition therapy, and diabetic counseling. 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. The $20 or $35 Copayment applies to non-emergency Physician services received in the emergency room of a Hospital. This Copayment applies to the charge for the Physician visit only.

2. Inpatient Medical and Surgical Services

90% Preferred Provider and Out-of-Area
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.

3. Other Physician Services

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Physician services received during an office visit (e.g., lab work or stitching a wound) are subject to the Maximum Calendar Year Medical Financial Responsibility limits. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician.

Services received from a Non-Preferred Provider have no Coinsurance limits.

NOTE: Visits and consultations by an ophthalmologist for an active illness are covered under the Physician Services Benefit described above. Routine foot care, such as toenail trimming, is covered when provided during a covered Physician office visit in conjunction with treatment of diabetic or circulatory disorders of the lower limbs. Physician visits determined to be Emergency Services and received in an emergency room are covered under the Emergency Care Benefit. Physician services related to mental health or substance use disorders are covered under the Mental Health and Substance Use Disorder Services Benefit. Physician services related to surgery are covered under Hospital Benefits. Services related to chiropractic care are covered under the Chiropractic and Acupuncture Benefit.

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

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 Health 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.

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.

You may call Included Health at 855-633-4436 for additional information about these services. You may also view websites from the federal and state government:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-015-AssemblyBill144andCoverageofPreventiveCareServices(9_18_2025).pdf

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/publichealth4all/vaccines.aspx

This benefit does apply to screenings. For example:

• A routine mammogram screening for breast cancer. This benefit does not apply to treatment or follow-up testing. For example:

• Follow-up mammogram after abnormal results or cancer treatment.

Prior to receiving the indicated services, please discuss with your Physician regarding the nature of the tests and procedures. For colonoscopy benefit, refer to the Colonoscopy Services section on page 44.

Reconstructive Surgery

90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Prior authorization must be obtained prior to services provided. 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.

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.

Retail Health Clinics

$35 Copayment Preferred Provider (Office Visit)
90% Preferred Provider (Other services)
60% Non-Preferred Provider

Retail 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 $35 Copayment applies to services and supplies provided by Physician assistants and/or nurse practitioners who provide basic medical services in a Retail Health Clinic. This Copayment applies to the charge for the Physician visit only. The Coinsurance for Covered Services at a Preferred retail health clinic is the same as the Coinsurance at your Physician's office. Other Physician services rendered during an office visit in a Retail Health Clinic are paid at 90% of the Allowable Amount for Preferred Providers.

Skilled Nursing Facility Services

90% first 10 days, Preferred Provider
80% next 170 days, Preferred Provider
60% Non-Preferred Provider

Subject to all of the Inpatient Hospital services provisions under the Hospital Benefits section, Medically Necessary skilled nursing services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and prior authorized. This Benefit is limited to 180 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 The Hospice Care Benefit.

Smoking Cessation Program

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.

Transgender Surgery

Inpatient Care or Outpatient Care (Facility-Based)
90% Preferred Provider and Out-of-Area
60% Non-Preferred Provider

Each time you are admitted to a Hospital on an inpatient basis, you are responsible for paying a separate $250 Copayment per hospital admission. This Copayment does not apply to the Calendar Year Deductible. It does apply to the Out-of-Pocket Maximum.

Prior authorization must be obtained 5 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 increasing your Coinsurance and liability responsibility by the application of financial sanctions and/or denial of Benefits.

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 the Travel and Lodging Benefits section for more information.

As part of your enrollment in the PERS Platinum 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.

Transplant Benefits

1. **Special Transplant Benefits**

   90% at Centers of Excellence (COE) -Hospital Services, Evaluations and Diagnostic Tests

   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 Platinum's 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 and is not 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 Platinum approved Transplant Network, call Included Health at 855-633-4436.

The following procedures are eligible for coverage under this provision:

a. Human heart transplants;
b. Human lung transplants;
c. Human heart and lung transplants in combination;
d. Human liver transplants;
e. Human pancreas transplants;
f. Human kidney and pancreas or kidney and liver transplants in combination (kidney only transplants are covered under the Organ Transplant Benefit below);
g. Human bone marrow transplants, peripheral stem cell transplantation, or umbilical cord transplants;
h. Human small bowel transplants;
i. 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 the Travel and Lodging Benefits section for more information.

2. Organ Transplant Benefits

90% 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.

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

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 272530
Chico, CA 95927

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.

Urgent Care

$35 Copayment, Preferred Provider (Physician office visit or Urgent Care Center visit)

90% Preferred Provider and Out-of-Area
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 90% of the Allowable Amount.

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

Virtual Care Services

Benefits are covered for virtual care or telehealth services. Included Health provides virtual care services for your plan. Please reach out to Included Health to set up an appointment at 855-633-4436 or you can set one up in the app.

To use Included Health virtual care services through the app:

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 *the type of provider you would like to see (primary care, first available appointment or therapy).*
e. Follow the page-by-page instructions.
f. Once you've completed the intake instructions, you will be connected with the next available provider.

1. Virtual Behavioral Health Services

$20 Copayment Included Health Virtual Provider and Preferred Providers
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.

2. Virtual Primary Care Services

$20 Copayment Included Health Virtual Provider and Preferred Providers
60% Non-Preferred Provider

This Plan includes access to virtual primary care through your Blue Shield of California Provider Network and Included Health. Use the Included Health app to make a virtual primary care appointment.

3. Virtual Urgent Care Services

$35 Copayment Included Health Virtual Provider and Preferred Providers

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.

A fee may apply for late cancellations or missed appointments for virtual urgent care, virtual primary care, virtual therapy, or virtual psychiatry visits (collectively referred to as "virtual care" services). The cancellation fee for scheduled Physician visits is $30. The cancellation fee for behavioral health visits is the total contracted visit fee depending on the specific type of visit. Please contact Included Health for more information on applicable cancellation fees.

Benefit Limitations, Exceptions and Exclusions

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 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.** Dental services, as determined by the Plan, include, but are not limited to, services customarily provided by dentists in connection with the care, treatment, filling, removal, or replacement of teeth; treatment of gums (other than for tumors); treatment of dental abscess or granuloma; dentures; and preparation of the mouth for dentures (e.g., vestibuloplasty). Services related to bone loss from denture wear or structures directly supporting the teeth are excluded.

    Also excluded are dental services in connection with prosthodontics (dental prosthetics, denture prosthetics designed for the replacement of teeth or the correction, alteration or repositioning of the occlusion), orthodontia (dental services to correct irregularities or malocclusion Classes I through IV of the teeth) for any reason, orthodontic appliances, braces, bridges (fixed or removable), dental plates, pedodontics (treatment of conditions of the teeth and mouth in children) or periodontics, and dental implants (endosteal, subperiosteal or transosteal).

    Dental services or supplies as a result of an Accidental Injury, including dental surgery and dental implants, are not covered.

    Acute Care hospitalization and general anesthesia services are covered in connection with dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status. This applies if (1) the Member is less than seven years old, (2) the Member is developmentally disabled, or (3) the Member's health is compromised and general anesthesia is Medically Necessary. Services of a dentist or oral surgeon are excluded.

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 the Durable Medical Equipment Benefit and the Diabetes Care Benefit.

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 the Diagnostic/Laboratory Services Benefit, the Maternity Care Benefit, and the Preventive Health Services Benefit.

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

27. **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.

28. **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.

29. **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, Diabetes Prevention Program (DPP) Benefit, Home Infusion Therapy Benefit, Hospice Care Benefit and Physician Services 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.

30. **Organ Transplants.** Incident to an organ transplant, except as provided under The Transplant Benefits section.

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

32. **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.

33. **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.

34. 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.

35. Rehabilitation or Rehabilitative Care

a. Inpatient charges in connection with a Hospital stay primarily for environmental change, or treatment of chronic pain unless provided under the Hospice Benefit.

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

c. Any testing, training or Rehabilitation for educational, developmental or vocational purposes, except as specifically provided under the Autism Spectrum Disorder Benefit.

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

37. Residential 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.

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

39. **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.

40. **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;

41. **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.

42. **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.

43. **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.

44. **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.

45. **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.

46. **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.

47. **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 does not apply to the Benefits described in the Diabetes Prevention Program (DPP) Benefit. 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 CVS Caremark.

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

49. **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.

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:

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

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 if you were required to change health plans due to Employer or CalPERS plan termination and your provider is not in Blue Shield of California's Preferred Provider network, or if 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**
• An active course of treatment for an acute medical condition, or mental health or substance use disorder, including a maternal mental health condition • Treatment for a serious and complex condition, or as part of an active course of treatment for a serious chronic condition • Pregnancy care, regardless of trimester, or postpartum care • Care of a newborn up to 36 months of age • Surgery, procedure, or other treatment previously recommended and documented by provider • Inpatient care • Terminal illness treatment	Up to 12 months 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

To request continuity of care with a Former Preferred Provider, visit includedhealth.com/calpers or call Included Health at 855-633-4436 to 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 agree to certain conditions for your ongoing care. Once 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.

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 Copayment or Coinsurance.

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.

Visit blueshieldca.com/en/home/be-well/services-requiring-authorization to view Blue Shield of California's prior authorization list. 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 Medical and Hospital Benefits 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 prior authorization of oncology services, your Physician must call 1-888-999-7713.

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.

Certain advanced imaging services are subject to prior authorization and Medical Necessity review. Medical Necessity review may include consideration of the setting in which the service will be performed. Coverage of an advanced imaging service does not guarantee approval of the requested site of care. Prior authorization for a Hospital-based imaging setting may be denied when the requested setting is not determined to be Medically Necessary, even if the imaging service itself is determined to be Medically Necessary.

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 the Durable Medical Equipment Benefit).
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.
19. Advanced Imaging in a hospital setting.

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), Neuropsychological and 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.

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.

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 272530
Chico, CA 95927-2530

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.

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.

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

Blue Shield of California uses utilization review to help you and your providers identify the most appropriate and cost-effective way to use the Benefits of this Plan. Visit blueshieldca.com/en/home/be-well/services-requiring-authorization to view Blue Shield of California's medical policies and prior authorization list, which are used to determine utilization review criteria.

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 CVS Caremark 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 Health Benefits Compliance & Appeals Unit
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information Blue Shield of California or CVS Caremark may have regarding your dispute with your request for Administrative Review, please note that Blue Shield of California or CVS Caremark 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 CVS Caremark 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.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, 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 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.

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.

CalCOBRA Continuation of Group Coverage

COBRA enrollees who became eligible for federal COBRA coverage on or after January 1, 2003, and have exhausted their 18 month or 29 month maximum continuation coverage available under federal COBRA provisions may be eligible to further continue coverage for medical benefits under the California COBRA

Program (CalCOBRA) for a maximum period of 36 months from the date the Plan Member's federal COBRA coverage began.

Qualifying Events
COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under CalCOBRA.

Notification Requirements
You will receive notice from Blue Shield of California of your right to possibly continue coverage under CalCOBRA within 180 days prior to the date your federal COBRA will end. To elect CalCOBRA coverage, you must notify Blue Shield of California in writing within 60 days of the date your coverage under federal COBRA ends or the date of notification of eligibility, if later.

Effective Date of CalCOBRA Continuation of Coverage
If elected, this continuation will begin after the federal COBRA coverage ends and will be administered under the same terms and conditions as if COBRA had remained in force.

Premiums
Premiums for this continuation coverage may not exceed:

1. 110% of the applicable group premiums rate if coverage under federal COBRA ended after 18 months; or

2. 150% of the applicable group premiums rate if coverage under federal COBRA ended after 29 months.

The first payment is due along with the enrollment form within 45 days after electing CalCOBRA continuation coverage. This payment must be sent to Blue Shield of California by first class mail or other reliable means of delivery, in an amount sufficient to pay any required premiums and premiums due. Failure to submit the correct amount within this 45-day period will disqualify the former Employee or Family Member from receiving continuation coverage under CalCOBRA. Succeeding premiums are due on the first day of each following month.

The amount of monthly premiums may be changed by Blue Shield of California as of any premiums due date. Blue Shield of California will provide enrollees with written notice at least 30 days prior to the date any increase in premiums goes into effect.

Termination of CalCOBRA Continuation of Coverage

This CalCOBRA continuation of coverage will remain in effect for the specified period of time, or until any one of the following events automatically terminates the coverage:

1. the Employer ceases to maintain any group health plan; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee becomes covered under any other health plan; or
4. the enrollee becomes entitled to Medicare; or
5. the enrollee becomes covered under a federal COBRA continuation; or
6. the enrollee moves out of Blue Shield of California's service area; or
7. the enrollee commits fraud.

In no event will continuation of group coverage under COBRA, CalCOBRA or a combination of COBRA and CalCOBRA be extended for more than 3 years from the date the qualifying event has occurred which originally entitled the Plan Member to continue group coverage under this Plan.

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 Preferred 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 Platinum

When Covered Services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERS Platinum, 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 Platinum 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 Platinum 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 CVS Caremark®. 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 Tier 1 or Tier 2 on the CVS Caremark® formulary 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 bioequivalent 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 caremark.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 CVS Caremark® Specialty Pharmacy), and Maintenance Medications are subject to change. To find out which Medications are impacted, Members can visit CVS Caremark® on-line at caremark.com/calpers or call CVS Caremark® Member Services at **1-833-291-3649** (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; based on the day supply whether you select Generic, Preferred and Non-Preferred Brand Name Medications; and, for Brand-Name drugs (Tier 1, Tier 2, Tier 3), whether a bioequivalent generic drug is available.

Maintenance Medication can be filled for two Copayments for up to a 90-day supply at Home Delivery or a participating, in-network pharmacy.

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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 Copayment structure includes Generic, Preferred and Non-Preferred Brand-Name medications at Tier 1, Tier 2 and Tier 3. The Member has an incentive to use Generic and Preferred Brand- Name Drugs, at CVS Caremark Home Delivery or retail Pharmacies.

Coinsurance, "Member Pays the Difference" and "Partial Copay Waiver"

- Erectile or Sexual Dysfunction Drugs are subject to a 50% Coinsurance.

- "Member Pays the Difference": If a Brand-Name Medication, either preferred or non-preferred in either Tier 2 or Tier 3, is selected when a bioequivalent generic drug is available, Members will pay the difference in cost between the Brand Name Medication and the bioequivalent generic, plus the Generic Copayment You may apply for a Member Pays the Difference Exception by contacting CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711) to request an Exception form. Your Physician must document the Medical Necessity for the Brand product(s) versus the available bioequivalent generic drug alternative(s).

- "Partial Copay Waiver": Partial copay waivers may reduce your out-of-pocket responsibility for non-preferred medications. You may apply for a Partial Copay Waiver Exception only for Non-Preferred Brand Medications by contacting CVS Caremark® Member Services at 1-833-291-3649 (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 from Partial Copay Waiver and Member Pays the Difference Exception programs.

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 Platinum Basic PPO ID card.

There are many Participating Pharmacies outside California that will also accept your PERS Platinum Basic PPO ID card. At Participating Pharmacies, simply show your ID card to receive up to a 30-day supply by paying either:

- Tier 1 medication: $5

- Tier 2 medication: $20

- Tier 3 medication: $50

- Partial Copay Waiver not applicable for retail

Outpatient Prescription Drug Program

Maintenance medications for long-term or chronic conditions may be obtained at CVS Caremark Home Delivery or at a participating, in-network retail pharmacy for two copayments up to a 90-day supply. This allows you to choose an in-person retail experience at the Plan's lower Home Delivery copayment structure.

- Tier 1 medication: $10
- Tier 2 medication: $40
- Tier 3 medication: $100
- Partial Copay Waiver not applicable for retail

To find a Participating Pharmacy close to you, simply visit the CVS Caremark® website at caremark.com/calpers or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711).

Home delivery program ("Home Delivery")

Maintenance medications for long-term or chronic conditions may be obtained by mail, for up to a 90-day supply, through the CVS Caremark Home Delivery Program. Home Delivery offers additional savings, specialized clinical care and convenience if you need prescription medication on an ongoing basis. For example, you can receive up to a 90-day supply of Medication for only:

- Tier 1 medication: $10
- Tier 2 medication: $40
- Tier 3 medication: $100
- Tier 3 medication with Partial Copay Waiver: $70
- Partial Copay Waiver not applicable for retail

Please note that all prescriptions mailed by the CVS Caremark Home Delivery Program will be subject to the copays above regardless of quantity.

- Convenience: Your medication is delivered to your home by mail.
- Security: You can receive up to a 90-day supply of medication at one time.
- A toll-free member services number: Your questions can be answered by contacting CVS Caremark Member Services at 1-833-291-3649 (TTY users call 711).

How to use CVS Caremark Home Delivery

If you must take Medication on an ongoing basis, CVS Caremark 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 CVS Caremark® electronically (known as e-prescribing) or to fax the Prescription. CVS Caremark® can only accept faxed Prescriptions from Prescribers.

3. Set up an online account at caremark.com/calpers. Then, log in and select Get Started. Choose which Medication you would like to receive through Caremark Home Delivery.

4. Call CVS Caremark® at 1-833-291-3649 (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 CVS Caremark®. Forms can be downloaded from caremark.com/calpers.

    a. Along with your completed form, you must send the following to CVS Caremark®:

    b. The original Prescription Order(s) – Photocopies are not accepted.

    c. If you are not paying with a credit card, you must include a check or money order payable to CVS Caremark® for an amount that covers your Copayment for each Prescription.

To order home delivery refills from CVS Caremark®, select one of the following options:

1. Log in to your online account. Select the Medications you wish to refill.

2. Download the CVS Caremark® App for your Apple® or Android™ smartphone. Open the app and under Manage Prescriptions click Refill Prescriptions. Choose which Medication you want to refill.

3. Call CVS Caremark® at 1-833-291-3649 (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 CVS Caremark®. CVS Caremark® also includes a return envelope in each order.

New Prescriptions that CVS Caremark® 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. 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 CVS Caremark® at 1-833-291-3649 (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 CVS Caremark® to give us your preferred phone number.

Outpatient Prescription Drug Program

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

Take your Prescription to any Participating Pharmacy*. Present your PERS Platinum Basic PPO ID card to the pharmacist. The pharmacist will fill the Prescription for up to a 90-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 a CVS Caremark® 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.

Note that using a non-participating pharmacy or not using your ID card at a participating pharmacy could result in a higher cost for you than if you use your ID card at a participating pharmacy. See example below.

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.

Using a non-participating pharmacy or not using your ID card at a participating pharmacy could result 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.

Example of a Direct Reimbursement Claim for a 30-day Tier 2 Medication*	
Retail Pharmacy charge to you	$48
Minus the CVS Caremark® 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, your Copayment for a Tier 2 Medication	$20
Your total financial cost would be	$38

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 CVS Caremark® Prescription Reimbursement Claim Form and mail the form along with your Pharmacy receipt to CVS Caremark®. Receipts must be submitted in English. For additional claim reimbursement information, visit the CVS Caremark® website at caremark.com/calpers, or call CVS Caremark® at 1-833-291-3649 (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 a CVS Caremark® Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the website at caremark.com/calpers, or contact CVS Caremark® Member Services at 1-833-291-3649 (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 CVS Caremark® Member Services at 1-833-291-3649 (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 CVS Caremark® 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 CVS Caremark®

You should always submit a payment to CVS Caremark® when you order Prescriptions through CVS Caremark® Home Delivery, just as if you were ordering a Prescription from a retail Pharmacy. CVS Caremark® accepts the following as types of payment methods:

- Check/Money Order
- Credit Card/Debit Card - Visa®, MasterCard®, Discover®, American Express®, Diners Club®
- ACH Payments
- Pay at Retail – Allows members to ship to a CVS Pharmacy (Ship to Retail orders only).

CVS Caremark® recommends keeping a credit card on file for Copayments. You can securely set up your credit card through your online account or by calling CVS Caremark®. Then, each time you refill a Prescription, CVS Caremark® will bill the copayment amount to the default credit card on file.

Go to caremark.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 CVS Caremark® 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 to stay on your current medication.

- 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 CVS Caremark® Member Services at **1-833-291-3649** (TTY users call 711) or visit caremark.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 Formulary Search Tool on the CVS Caremark® 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 CVS Caremark® of the prior authorization outcome within a few days. Some medications that require prior authorization may be subject to quantity limits.

Please visit the CVS Caremark® website at caremark.com/calpers, use the Formulary Search Tool in the CVS Caremark® App or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711) to determine if your medication requires prior authorization.

CVS Caremark® Specialty Pharmacy Services ("CVS Caremark® Specialty Pharmacy")

The CVS Caremark® 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. A CVS Caremark® 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 CVS Caremark® Specialty Pharmacy at **1-800-237-2767**. CVS Caremark® Specialty Pharmacy hours of operation are 8:00 AM to 8:00 PM EST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact CVS Caremark® Specialty Pharmacy at **1-800-237-2767** 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 CVS Caremark® Coverage Management Programs.

3. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through CVS Caremark® 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., multi- vitamins, 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, with the exception of Palforzia. *

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

CVS Caremark® 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 CVS Caremark® Member Services at 1-833-291-3649 (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 via email, phone, or in writing to CVS Caremark®. If your request is denied, the written response from CVS Caremark® 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 CVS Caremark® to review its determination is the responsibility of you or your Authorized Representative requesting the review.

To file a complaint regarding the prescription plan or services please call CVS Caremark (CVS) Customer support 24 hours a day, 7 days a week at 833-291-3649. You can expect to receive letter within 5 calendar days of the complaint acknowledging receipt of the complaint and a response letter to your concern within 30 calendar days. In some cases, if CVS resolves your concern to your satisfaction within 24 hours of receipt, CVS will not send any written correspondence.

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 CVS Caremark®. This review is subject to the Internal Review process described in section 2. below.

Non-specialty appeals address:
Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax 866-443-1172
Specialty appeals:
CVS Caremark

Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056
Fax 855-230-5548

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for Prescription Drugs are not payable when first submitted to CVS Caremark®. If CVS Caremark® determines that a claim is not payable in accordance with the terms of the Plan, CVS Caremark® will notify 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 CVS Caremark®. If after resubmission the claim is determined to be payable in whole or in part, CVS Caremark® will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, CVS Caremark® will inform you in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the denial made by CVS Caremark®, you may request an Internal Review as described in section 2. below.

c. Internal Review

You may request a review of an ABD by writing to CVS Caremark® within 180 days of receipt of the ABD. Requests for Internal Review should be directed to:

Prescription Claim Appeals MC 109
CVS Caremark

P.O. Box 52084
Phoenix, AZ 85072
Fax 866-443-1172

The request for review must clearly state the issue of the review and include the identification number listed on the CVS Caremark® 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 CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711).

CVS Caremark® will acknowledge receipt of your request within 5 calendar days for standard Post-Service reviews in writing. If your matter is considered a standard Pre-Service or Concurrent request, CVS will verbally acknowledge your request within 24-hours of receipt CVS Caremark® will provide a determination within 14 days of the initial request for Internal Review.

For standard reviews of Prescriptions or services that have been provided (Post-Service Appeal), CVS Caremark® will provide a determination within 30 days of the initial request for Internal Review.

If CVS Caremark® 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.

d. Urgent Review

An urgent appeal is verbally acknowledged within 4-hours of receipt and resolved within 72 hours upon receipt of the request, but only if CVS Caremark® 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 CVS Caremark® determines the appeal request does not meet one of the above requirements, the appeal 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.

e. 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 CVS Caremark® 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.

f. 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 CVS Caremark® 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."

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 the CVS Caremark 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. For objections to claim processing, the request must be submitted within 30 days of CVS Caremark affirming its decision regarding the claim or within 60 days from the date you sent the objection regarding the claim to CVS Caremark and CVS Caremark failed to respond within 30 days of receipt of the objection.

The request must be mailed to:

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

If you are planning to submit information CVS Caremark may have regarding your dispute with your request for Administrative Review, please note that CVS Caremark may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after CVS Caremark 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 satisfactory showing of 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 your case not

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

3. Appeal beyond Administrative Review and Administrative Hearing

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

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

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 Platinum 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.

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 CVS Caremark® terms and conditions as a Participating Pharmacy. Members may visit the CVS Caremark® website at caremark.com/calpers or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711) to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication(s) (Non-Preferred Brand-Name Drug(s)) - Brand name medications that are recognized as non-preferred on the formulary and that are covered under your

Plan will require the highest copayment. If you would like to request a copy of the CVS Caremark® formulary, please visit the CVS Caremark® website at caremark.com/calpers, or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711). All medications on the CVS formulary are evaluated based on the following criteria: safety, side effects, drug-to-drug interactions, and cost effectiveness.

Over-the-counter Drugs (OTC) - A Drug product that does not require a Prescription under federal or state law. PERS Platinum 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 CVS Caremark® to provide Prescription Drug services to Plan Members. Members may visit the CVS Caremark® website at caremark.com/calpers or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711) to locate a Participating Pharmacy.

Preferred Brand-Name Medication(s) (Preferred Brand-Name Drug(s)) - Brand name medications that are recognized as preferred on the formulary and that are covered under your Plan. All medications on the CVS Caremark® formulary are 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 CVS Caremark® formulary, please visit the CVS Caremark® website at caremark.com/calpers or contact CVS Caremark® Member Services at 1-833-291-3649 (TTY users call 711).

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 for a chronic or complex disease; (2) produced through DNA technology or biological processes; (3) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (4) unique patient compliance and safety monitoring requirements; (5) unique requirements for handling, shipping and storage; or (6) 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, the lesser of:

   a. The amount determined by Blue Shield of California as the appropriate payment for the services rendered in the provider's geographic area based on factors such as Blue Shield of California's Preferred Providers performing the same or similar services, market conditions, and provider charge patterns.

   b. A negotiated amount agreed upon between Blue Shield of California and the provider as the accepted payment amount for the services rendered.

   c. Another amount Blue Shield of California determines is appropriate considering the particular circumstances and services rendered.

   d. The provider's billed charges.

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 Coinsurance 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 –

An Alternative Birthing Center is defined as:

1. a birthing room located physically within a Hospital to provide homelike Outpatient maternity facilities, or

2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

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.

Definitions

Behavioral Health Treatment – professional services and treatment programs, including applied behavior 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.

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.

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

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 terminating at 12 midnight Pacific Standard Time on December 31 of the same 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.

Centers of Excellence (COE) — Facilities that have a Centers of Excellence designation in effect with Blue Shield of California at the time services are rendered. COE agrees to accept the Plan payment plus applicable Member Deductibles and Copayments and/or Coinsurance as payment in full for Covered Services.

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.

Coinsurance - is a set percentage (e.g., 10% / 40%) defined in the Plan and paid by the Member for certain Covered Services, often after the Member pays the Calendar Year Deductible. When using a Preferred Provider, the Member will need to pay the set percentage Coinsurance until the Member meets the

Maximum Calendar Year Coinsurance Responsibility. When using a Non-Preferred Provider, the percentage the Member pays for Covered Services is higher, and the Coinsurance does NOT accumulate toward the Maximum Calendar Year Coinsurance Responsibility.

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.

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 - is a set fixed dollar amount (i.e., office visit copay) defined in the Plan and paid by the Member for certain 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 Group Health Service Agreement.

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.

Deductible - the amount you owe for health care services the Plan covers before it begins to pay.

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.

Definitions

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 U.S. 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.

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 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.

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.

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 for nine to nineteen hours a week.

Inter-Plan Programs – Blue Shield of California's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

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.

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) – see the Medical Necessity section on page 25.

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, behavioral, and neurodevelopmental disorders chapter (or equivalent 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 Preferred 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 - a group of Physicians, Hospitals or other Health Care Providers that (1) do not have a contract with Blue Shield of California at the time services are rendered, or (2) do not participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be Non-Preferred Providers: Physicians, Hospitals, Ambulatory Surgery Centers, home health agencies, facilities providing diagnostic imaging services, Durable Medical

Equipment providers, skilled nursing facilities, clinical laboratories, urgent care providers and home infusion therapy providers. An individual Preferred Provider may be considered a Non-Preferred Provider if (1) services are rendered at a location other than specified in the Preferred Provider contract or (2) the tax identification number used for billing purposes is different than specified in the contract.

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 - A geographic area where a Member does not have reasonable access to a Preferred Provider, including Members traveling or residing in a foreign country. Please refer to the Qualifying Out-of-Area Zip Codes section to determine if you live or work in one of the qualifying Out-of-Area zip codes listed.

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.

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.

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 Platinum Basic PPO Health Plan.

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.

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 Preferred 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. Individual providers at a Preferred Hospital may not be Preferred Providers.

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 group of Physicians, Hospitals or other Health Care Provider that (1) have a contract in effect with Blue Shield of California at the time services are rendered, provides a service at a

location set forth in the provider's contract, and bills Blue Shield of California utilizing the tax identification number (TIN) under the terms of that Agreement for those services rendered, or (2) participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered.

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.

Reasonable Charge - charge Blue Shield of California considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Reconstructive Surgery - surgery to correct 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.

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 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.

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.

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.

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.

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 - Services received for a sudden and unexpected serious illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

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 the Hospital Benefits section).

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.

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.

PERS Platinum 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 Platinum 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, 91309, 91310, 91311, 91313, 91316, 91321, 91322, 91324, 91325, 91326, 91327, 91328, 91329, 91330, 91331, 91333, 91334, 91335, 91337, 91340, 91341, 91342,

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Madera	93601, 93602, 93604, 93610, 93614, 93620, 93622, 93623, 93626, 93636, 93637, 93638, 93639, 93643, 93644, 93645, 93653, 93669, 93720
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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, 92624, 92625, 92626, 92627, 92628, 92629, 92630, 92637, 92646, 92647, 92648, 92649, 92650, 92651, 92652, 92653, 92654, 92655, 92656, 92657, 92658, 92659, 92660, 92661, 92662, 92663, 92672, 92673, 92674, 92675, 92676, 92677, 92678,

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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
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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, 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

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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
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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
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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, 95050, 95051, 95052, 95053, 95054, 95055, 95056, 95070, 95071, 95076, 95101, 95103, 95106, 95108, 95109, 95110, 95111, 95112, 95113, 95115, 95116, 95117, 95118, 95119, 95120, 95121, 95122, 95123, 95124, 95125, 95126, 95127, 95128, 95129, 95130, 95131, 95132, 95133, 95134, 95135, 95136, 95138, 95139, 95140, 95141, 95148, 95150, 95151, 95152, 95153, 95154, 95155, 95156, 95157, 95158,

	95159, 95160, 95161, 95164, 95170, 95172, 95173, 95190, 95191, 95192, 95193, 95194, 95196
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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
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Solano	94503, 94510, 94512, 94533, 94534, 94535, 94571, 94585, 94589, 94590, 94591, 94592, 95616, 95618, 95620, 95625, 95687, 95688, 95690, 95694, 95696
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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
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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, 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

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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 بالاتصال 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): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວຟຣີ, 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.

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