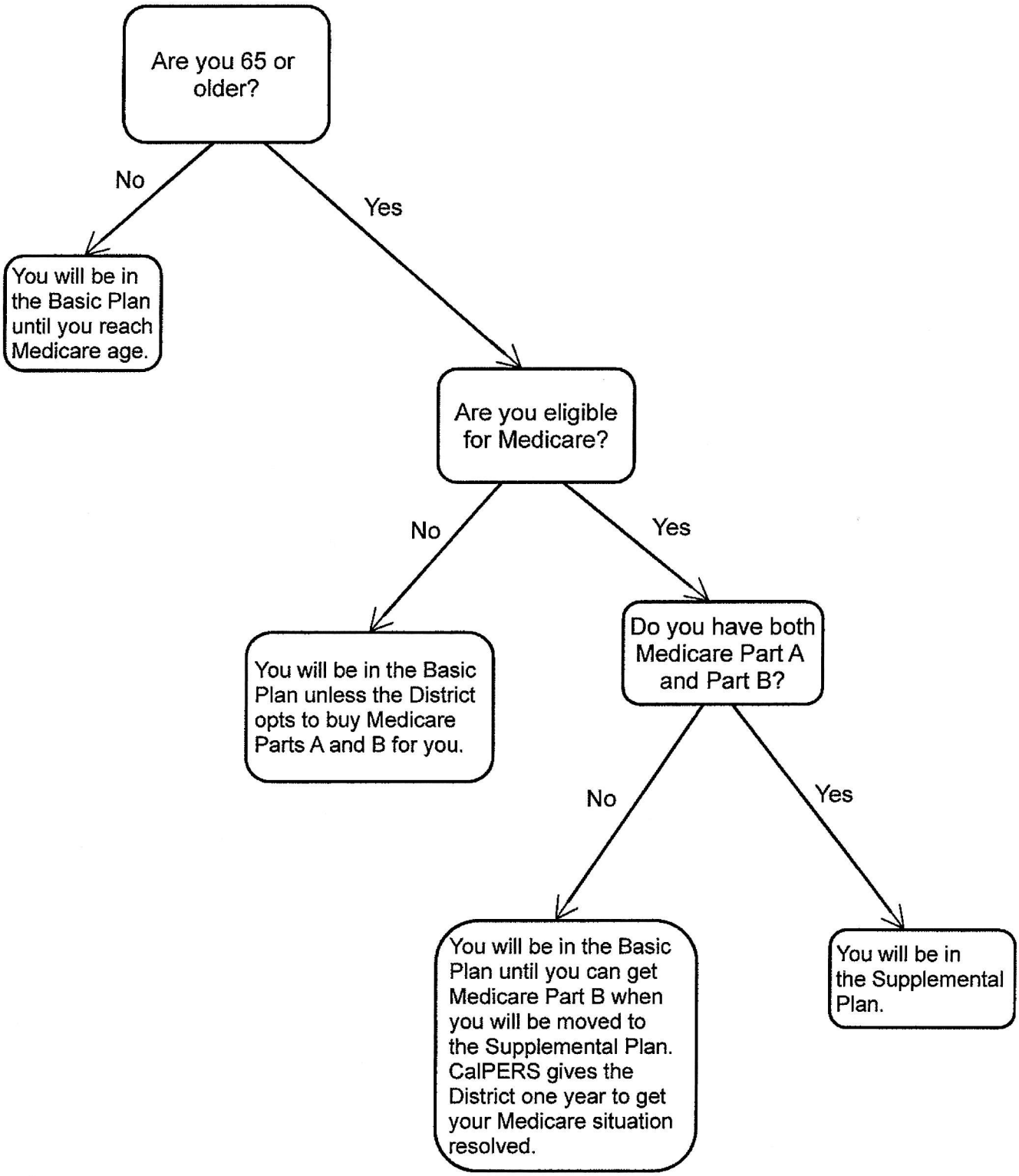
Retiree Flowchart
for
Meeting on CalPERS Healthcare
Feb.5, 2020



When I volunteered to compare the coverage under Anthem to the coverage under CalPERS, I only had the Evidence of Coverage (EOC) for the ASCC Plan for 2016-2019. I did not acquire access to the Faculty EOC until the 2019 document became available. I also used the ***MES Vision Plan*** EOC dated July 1, 2014. For Medicare Supplement coverage, I used the ***Medicare and You 2019*** book as well.

I then downloaded and printed copies of the EOCs for 2019 for

- ***PERS Choice Basic***,
- ***PERS Care Basic***,
- ***PERS Care Supplement***, and
- ***PERS Choice Supplement.***

When the EOC for ***PERS Choice Medicare Part D Prescription Drug Coverage for Jan. 1, 2020-Dec. 31, 2020*** became available, I downloaded and printed it too. That is a plan provided by OptumRX, and their agent assured me that PERS Choice and PERS Care had exactly the same for prescription drug coverage.

It is important to be aware that the plans with PERS in the title are self-insured plans. Our current Anthem plan is an insurance company product which means that it is subject to oversight by the California Department of Managed Care. Self-insured plans are governed by federal law, and that means that the State of California has no jurisdiction over them.

The plans offered by CalPERs are either Basic or Supplement. The two types of plans are very different. They have different rules, conditions, and even oversight. Please do not get the two types confused.

Major Differences for Retirees with Medicare Parts A and B

1. CalPERS insurance is a supplement to Medicare not secondary insurance. This means that if Medicare won't pay, CalPERS won't pay either with a very few exceptions. Generally, if Medicare pays, Medicare pays 80%, Supplement pays 20%, and insured pays 0%. If Medicare doesn't pay, Medicare pays 0%, Supplement pays 0%, and insured pays 100%. Currently the District is offering **PERS Choice Supplement**.

2. Coverage will be the equivalent of Medicare Parts A and B, a Medicare Supplement, and Medicare Part D.

3. CalPERS supplement plans have the benefit of no financial penalties and far fewer preapprovals than the Basic Plans. However, if you use a facility or provider that does not participate in Medicare, you will pay 100%, and there is no out-of-pocket maximum. There is the cost of Medicare Part B to consider as well, but many covered services will cost $0. (Note: The pharmacy plan for Medicare beneficiaries has a slightly better formulary but nearly as many conditions for coverage as the one offered by the Basic Plans.)

4. The exceptions are called "Benefits Beyond Medicare", and most require filling out forms and getting reimbursements rather than having CalPERS pay upfront.

5. How much you will pay for Medicare coverage is unclear.

Major Differences for Active Employees, Retirees Younger than 65, Those Ineligible for Medicare Who Are over 65, and Those With Medicare Part A Only

1. The District is currently offering **PERS Choice Basic Plan**. There is no limit for out-of-pocket costs if you use a non-participating provider, and CalPERS pays nothing if it becomes insolvent. With our current Anthem Plan, the worst-case scenario is an out-of-pocket maximum of $9000 per family under both the ASCC and Faculty Plans even if you use non-participating providers. Under PERS, there are also financial penalties for not getting precertification when it is required, and there is a long list of those requirements.

2. None of California legal protections apply. The most recent California protections state that non-participating providers at a participating hospital cannot charge you more than a participating provider, and in an emergency, a non-participating hospital in California can't charge you more than an participating hospital. Those protections are in our current Anthem plans, and those rules do not apply and are not included in the CalPERS Basic Plans. [Note: Even with Anthem, these protections do not apply if you move or travel out of state.]

3. Certain very common procedures must be performed at Ambulatory Surgical Centers if you want to guarantee that CalPERS will pay with "no benefit maximum". If you go elsewhere, you may pay the entire amount over what CalPERS has established as a maximum.

4. You won't just pay 20% for a non-participating provider at a participating facility. You will pay 20% "plus the excess". Emergency services at non-participating hospitals will also cost 20% "plus the excess", and there is no out-of-pocket maximum!

5. Mental health and autism are not covered to the same extent that we are currently covered.

6. Donor costs are not paid for in some cases. That may affect whether or not a live donor will donate an organ.

7. Prescription coverage is incredible convoluted. I have asked for a second presentation from OptumRX.

It is worth stating that it isn't just the major differences among the plans that will lead us to increased costs. For example, current costs to visit a physician are: $20 for ASCC and 20% for Faculty. The new costs will be $20 for primary physicians and $35 for specialists. Those who visit doctors frequently will find that their costs will go up considerably. The faculty will find that they will be subject to a formulary for their prescriptions, and ASCC members will find that their formulary covers fewer/different drugs. Use of an out-of-network pharmacy means that the participant must pay out of pocket and hope to be reimbursed. There are many covered services for which we will need to either ask for permission or apply for reimbursement. These include physical therapy beyond 24 visits per year and chiropractic beyond 20 visits per year. If anything goes wrong in any of these circumstances, we can only appeal to CalPERS.

Special Notes For Retirees with Medicare Part A only

1. CalPERS requires that you get Part B within a year of joining CalPERS. If you do not, CalPERS will remove you from their coverage.

2. Those in this group will be in a Basic Plan until they obtain Medicare Part B when they will be moved to the Supplement Plan.

3. As you may already know, late enrollment in Medicare Part B is subject to penalties that never expire. No one knows if the District will pay for those penalties nor for how long.

THE FOLLOWING FOUR PAGES APPLY ONLY TO CALPERS BASIC PLANS. THEY DO NOT APPLY TO ANY CALPERS SUPPLEMENT TO MEDICARE PLAN.

(The pages are from PERS Choice, Evidence of Coverage, Effective January 1, 2019-December 31, 2019)

FINANCIAL SANCTIONS

You may incur unnecessary medical expenses if the Review Center is not notified and involved in the Precertification and management of your care. In order to promote compliance with utilization review notification requirements, financial sanctions (increased Copayment or Coinsurance responsibility) will be applied if you fail to notify the Review Center as required. In addition, if the Review Center determines that services are not Medically Necessary or are being provided at a level of care inconsistent with acceptable treatment patterns found in established managed care environments, financial sanctions will be applied and/or denial of all or some services may occur.

If you have questions about the application of a sanction based on the Review Center's decisions regarding compliance with late notification requirements, call the Review Center at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your Physician may appeal this decision by following the Medical Claims Review And Appeals Process described on pages 79-80.

For questions about how a sanction was applied to a specific claim, call Anthem Blue Cross at 1-877-737-7776.

Non-Compliance With Notification Requirements

A 10% Coinsurance (in addition to any other required Copayment or Coinsurance) will be applied to **all covered Hospital charges** associated with the Hospital Stay in question if Inpatient Hospital services are received and (a) notification is late, or (b) Precertification was not obtained even though services were approved after retrospective review.

A 10% Coinsurance (in addition to any other required Copayment or Coinsurance) will be applied to **Outpatient facility charges and professional charges*** if services listed under Utilization Review — Services Requiring Precertification on pages 64-67 are received in an Outpatient facility or in a Physician's office and (a) notification is late, or (b) services were approved after retrospective review.

This additional Coinsurance amount will not accrue toward satisfying any other out-of-pocket Deductible or the Maximum Calendar Year Medical Financial Responsibility required under the payment design of the Plan.

*Note: This additional Coinsurance will not apply to emergency admissions and related emergency services, Medically Necessary transfers from one facility to another, or to advanced imaging procedures including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging if notification is late or services were approved after retrospective review.

Non-Compliance With Medical Necessity Recommendations for Temporomandibular Disorder Benefit or Maxillomandibular Musculoskeletal Disorders Services

A penalty of $500 will be assessed on Inpatient charges or $250 on Outpatient charges for (a) failure to obtain the required Precertification from the Review Center, or (b) failure to comply with the Review Center's recommendation. This additional Copayment amount will not accrue toward satisfying any other out-of-pocket Deductible or the Maximum Calendar Year Medical Financial Responsibility required under the payment design of the Plan.

Non-Certification of Medical Necessity

If the Review Center decides that services are not Medically Necessary or are provided at a level of care not consistent with acceptable treatment patterns found in established managed care environments, the Review Center will advise the treating Physician and the patient, or a person designated by the patient, that coverage cannot be guaranteed. The actual amount of benefits paid will be determined retrospectively and will reflect appropriate sanctions, reductions, or denial of payment. For example, if you are hospitalized and the Review Center decides during the Stay that treatment can be provided in a less acute setting, charges associated with the treatment will be paid, but room and board charges for the number of days at the inappropriate level of care will not be paid. Therefore, if the Review Center declines to certify services as Medically Necessary but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the Plan.

Hospital Benefits

80% PPO and Out-of-Area
60% Non-PPO

All non-emergency hospitalizations and acute Inpatient Rehabilitation require Precertification by the Review Center as soon as possible, but no later than 3 business days before services are provided (except for maternity care and admissions for mastectomy or lymph node dissection). Certain Outpatient procedures, services and surgeries also require Precertification by the Review Center. Precertification is required no later than 3 business days prior to the start of services listed under Services Requiring Precertification on pages 64-67. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of coverage and within the specified time frame may result in increasing Coinsurance and liability responsibility by the application of financial sanctions (see page 30) and/or denial of benefits. For information on benefits for Hospital services related to Emergency Care Services, refer to page 42.

Note: Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting. 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.

Inpatient Services

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

Outpatient Services

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

The following are considered routine services and can be performed safely at an Ambulatory Surgery Center. If these routine procedures are performed in an Ambulatory Surgery Center (as defined on page 106), benefits will be paid according to the Plan (see Ambulatory Surgery Centers on page 33-34).

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

Anthem Blue Cross has a network of Ambulatory Surgery Centers that generally provide these services within the maximum benefit amount. No benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Member Services and/or visit www.anthem.com/ca/calpers to verify that the facility is listed as a preferred Ambulatory Surgery Center in Anthem Blue Cross' network.

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

- Colonoscopy services are limited to **a maximum payment of $1,500** per procedure (see Colonoscopy Services on pages 39-40).
- Cataract surgery services are limited to **a maximum payment of $2,000** per procedure (see Cataract Surgery on page 37).
- Arthroscopy services are limited to **a maximum payment of $6,000** per procedure (see Arthroscopy Services on page 34).
- Services for upper gastrointestinal endoscopy with biopsy are limited to **a maximum payment of $2,000** per procedure.
- Laparoscopic gall bladder removal services are limited to **a maximum payment of $5,000** per procedure.
- Upper gastrointestinal endoscopy services are limited to **a maximum payment of $1,500** per procedure.
- Services for hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage) are limited to **a maximum payment of $3,500** per procedure.
- Nasal/Sinus - submucous resection inferior turbinate services are limited to **a maximum payment of $3,000** per procedure.
- Tonsillectomy and/or adenoidectomy services, for a Member under age 12, are limited to **a maximum payment of $3,000** per procedure.
- Services for nasal/sinus - corrective surgery - septoplasty are limited to **a maximum payment of $3,500** per procedure.
- Services for lithotripsy - fragmenting of kidney stones are limited to **a maximum payment of $7,000** per procedure.
- Hernia inguinal repair (Members over age 5, non-laparoscopic) services are limited to **a maximum payment of $4,000** per procedure.
- Esophagoscopy services are limited to **a maximum payment of $2,000** per procedure.
- Services for repair of laparoscopic inguinal hernia are limited to **a maximum payment of $5,500** per procedure.
- Sigmoidoscopy services are limited to **a maximum payment of $1,000** per procedure.

Examples for an exception to the services listed above to be performed in an Outpatient Hospital include the following reasons:

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

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

Services Requiring Precertification

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

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

Precertification is required no later than 3 business days prior to the start of the following procedures, services and surgeries or purchase of Durable Medical Equipment:

- Inpatient hospitalization
- Acute Inpatient Rehabilitation
- Skilled Nursing Facility (see page 54)
- All Inpatient mental health or substance use disorder treatment (see pages 48 and 55)
- All Outpatient facility-based care for mental health or substance use disorder treatment (see pages 48-49 and 55-56)
- Temporomandibular disorder treatment and diagnostic services, including MRIs and surgeries
- Maxillomandibular musculoskeletal surgeries
- Septoplasty and sinus-related surgeries
- Specific Durable Medical Equipment (see pages 41-42)
- Bariatric surgeries
- Any plastic or reconstructive procedures/surgeries
- Skin transplants
- Any anesthesia administered by an anesthesiologist or nurse anesthetist during a colonoscopy
- Hip and knee joint replacement surgeries
- Additional Physical Therapy and Occupational Therapy visits beyond those provided under the Plan
- Additional Speech Therapy visits beyond those provided under the Plan
- Transgender surgery including travel expenses
- Hepatic Activation/Chronic Intermittent Intravenous Insulin Infusion Therapy/Pulsatile Intravenous Insulin Infusion Therapy Treatments

If you fail to obtain Precertification from the Review Center for the listed services, or if there are serious questions on the Plan's part as to the Medical Necessity or purpose for which a service was provided, the Review Center may review the services provided to you after they have been rendered. This is known as retrospective review. This review may result in a determination that reimbursement will be reduced or even denied under certain circumstances. Any subsequent adjustment in benefit levels as a result of retrospective review will be communicated to you in writing.

Even though services that require Precertification may ultimately be approved after retrospective review, financial sanctions (see page 30) may nevertheless be applied if the Member failed to obtain Precertification from the Review Center.