**9/17/2020**

**Grossmont-Cuyamaca Community College District**

**AFT Benefit Changes**

1. **Active Employees**
   1. District pays full cost for the following benefit plans:
      1. Kaiser HMO
      2. UHC HMO Network 1
      3. UHC Alliance $20/$30
      4. UHC Alliance HRA $1200
      5. SIMNSA HMO (Cross Border Plan)
   2. Employees on UHC HMO Network 2 will pay monthly contributions for the difference between this plan rate and UHC Alliance $20/$30 rate. Employees will have the option to switch to a district fully paid plan. Monthly contributions for the UHC HMO Network 2 for calendar year 2021 are:
      1. Single = $235
      2. Two Party = $489
      3. Family = $694

(Note:VEBA medical rates are not final until the District sends the signed renewal agreement to VEBA and VEBA delivers the final rates to the District – typically by mid-November.)

* 1. The PPO plan shall be discontinued. Upon discontinuance of the PPO plan, continuity of care will be provided to employees by their new provider as specified in California Health and Safety Code § 1373.96 (attached to this document) and in individual Kaiser and UHC provider documents (attached as separate documents). The District will work with VEBA and affected members to provide one-on-one counseling sessions in order to determine which would be the best plan for the member to transition to.
  2. Active employees who can demonstrate coverage in a VEBA approved plan through their spouse or domestic partner can elect to opt-out of the District plan and will receive a stipend equal to 50% of the single premium for the Kaiser plan.
     1. The amount of the monthly stipend for calendar year 2021 is $336.50
     2. Pending authorization from VEBA

1. **Retirees** 
   1. District pays full cost for Kaiser HMO and UHC HMO Network 1 plans for all retirees including the Out of State retirees.
      * 1. Retirees will pay the difference in premium between the plan they are on and Kaiser HMO premium
        2. No grandfathering for current employees
   2. The PPO plan shall be discontinued for retirees. Upon discontinuance of the PPO plan, continuity of care will be provided to employees by their new provider as specified in California Health and Safety Code § 1373.96 (attached to this document) and in individual Kaiser and UHC provider documents (attached as separate documents). The District will work with VEBA and affected members to provide one-on-one counseling sessions in order to determine which would be the best plan for the member to transition to.
   3. Retirees receiving District paid health coverage whose spouse is over age 65 shall be required to enroll their spouse in Medicare Part B.
      * 1. Still covered under the district’s plan
        2. No grandfathering for current employees
   4. Retirees who opt-out of coverage shall receive a stipend equal to 50% of the single premium for VEBA Kaiser plan.
      * 1. Grandfather current retirees.
        2. Pending authorization from VEBA
   5. Raise retirement age for benefit eligibility to 55 for PERS (aligns with STRS) and increase the years of service to 15 years.
      * 1. Grandfather current retirees
   6. Must retire from respective retirement system (STRS or PERS).
      * 1. Grandfather current retirees
   7. All grandfathered retirees are subject to plan design and cost sharing changes.
2. **Plan Design Changes**

**Kaiser HMO**

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| **Benefit** | **Current Kaiser HMO $10** | **Proposed Option  Kaiser HMO $15** |
| Deductible (Ind./Fam) | None | None |
| Medical Out-of-Pocket (Ind./Fam) | $1,500 / $3,000 | $1,500 / $3,000 |
| PCP Office Visit | $10 copay | $15 copay |
| Specialist Office Visit | $10 copay | $15 copay |
| Preventive Care | No charge | No charge |
| Inpatient Hospital Care | No charge | No charge |
| Mental Health Services (outpatient/inpatient) | $10 copay / No charge | $15 copay / No charge |
| Substance Abuse Services (outpatient/inpatient) | $10 copay / No charge | $15 copay / No charge |
| Diagnostic Laboratory Outpatient (standard) | No charge | No charge |
| Diagnostic and Complex Radiology (PET, MRI) | No charge | No charge |
| Outpatient Surgery | $10 copay | $15 copay |
| Outpatient Physical/Rehabilitation Therapy | $10 copay | $15 copay |
| Urgent Care (your medical group/other) | $10 copay | $15 copay |
| Emergency Room (copay waived if admitted) | $50 copay | $50 copay |
| Short-Term Prescription Drugs (generic/brand) | $10 copay up to a 30 day supply | $10 copay / $20 copay up to a 30 day supply |
| Maintenance Prescription Drugs (generic/preferred/non-preferred) | $10 copay up to a 100 day supply | $20 copay / $40 copay up to a 100 day supply |
| Chiropractor Service | $10 copay | $20 copay |

**UHC HMO Network 1**

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| --- | --- | --- |
| **Benefit** | **Current UHC HMO 1 Plan A** | **Proposed Option UHC HMO 1 Plan D** |
| Deductible (Ind./Fam) | None | None |
| Medical Out-of-Pocket (Ind./Fam) | $1,500 / $3,000 | $1,500 / $3,000 |
| Prescription Out-of-Pocket (Ind./Fam) | $3,000 / $6,000 | $3,000 / $6,000 |
| PCP Office Visit | $10 copay | $20 copay |
| Specialist Office Visit | $10 copay | $20 copay |
| Preventive Care | No charge | No charge |
| Inpatient Hospital Care | No charge | $250 copay per admit |
| Mental Health Services (outpatient/inpatient) | $10 copay / No charge | $20 copay / $250 copay per admit |
| Substance Abuse Services (outpatient/inpatient) | No charge | No charge |
| Diagnostic Laboratory Outpatient (standard) | No charge | No charge |
| Diagnostic and Complex Radiology (PET, MRI) | No charge | $100 copay |
| Outpatient Surgery | No charge | No charge |
| Outpatient Physical/Rehabilitation Therapy | $10 copay | $20 copay |
| Urgent Care (your medical group/other) | $10 copay / $50 copay | $20 copay / $75 copay |
| Emergency Room (copay waived if admitted) | $100 copay | $150 copay |
| Short-Term Prescription Drugs(generic/preferred/non-preferred) | $5 / $25 / 50%\*Extra $5 at non EAN pharmacy | $10 / $25 / 50%\*Extra $5 at non EAN pharmacy |
| Maintenance Prescription Drugs (generic/preferred/non-preferred) | $10 / $50 / 50% | $20 / $50 / 50% |
| Chiropractor Service | $10 copay | $20 copay |
| NETWORK | SHARP, RADY PRIMARY CARE ASSOCIATED MG, ARCH HEALTH PARTNERS MG, ENCOMPASS MG | SHARP, RADY PRIMARY CARE ASSOCIATED MG, ARCH HEALTH PARTNERS MG, ENCOMPASS MG |

**UHC HMO Network 2**

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| **Benefit** | **Current UHC HMO 2 Plan A** | **Proposed Option  UHC HMO 2 Plan D** |
| Deductible (Ind./Fam) | None | None |
| Medical Out-of-Pocket (Ind./Fam) | $3,000 / $6,000 | $5,000 / $10,000 |
| Prescription Out-of-Pocket (Ind./Fam) | $3,000 / $6,000 | $3,000 / $6,000 |
| PCP Office Visit | $20 copay | $30 copay |
| Specialist Office Visit | $20 copay | $40 copay |
| Preventive Care | No charge | No charge |
| Inpatient Hospital Care | No charge | $500 copay per admit |
| Mental Health Services (outpatient/inpatient) | $20 copay / No charge | $30 copay / $500 copay per admit |
| Substance Abuse Services (outpatient/inpatient) | No charge | No charge |
| Diagnostic Laboratory Outpatient (standard) | No charge | No charge |
| Diagnostic and Complex Radiology (PET, MRI) | No charge | $200 copay |
| Outpatient Surgery | No charge | $250 copay per admit |
| Outpatient Physical/Rehabilitation Therapy | $20 copay | $30 copay / $40 copay |
| Urgent Care (your medical group/other) | $20 copay / $50 copay | $30 copay / $100 copay |
| Emergency Room (copay waived if admitted) | $100 copay | $200 copay |
| Short-Term Prescription Drugs(generic/preferred/non-preferred) | $10 / $30 / 50%\*Extra $5 at non EAN pharmacy | $15 / $35 / 50%\*Extra $5 at non EAN pharmacy |
| Maintenance Prescription Drugs (generic/preferred/non-preferred) | $20 / $60 / 50% | $30 / $70 / 50% |
| Chiropractor Service | $20 copay | $30 copay |
| NETWORK | MERCY PMG, GREATER TRI-CITIES IPA,  MID-COUNTY PMG, MULTI-CULTUREAL PMG, SAN DIEGO PMG, RADY | MERCY PMG, GREATER TRI-CITIES IPA,  MID-COUNTY PMG, MULTI-CULTUREAL PMG, SAN DIEGO PMG, RADY |

* No proposed plan design changes for the UHC Alliance plans. Network for UHC Alliance Plans are Scripps, UCSD, and RADY.

1. **TIMELINE** 
   1. August 2020: Receive from VEBA plan designs and adjust plan accordingly
   2. August/Sept. 2020: Negotiations to finalize benefit changes
   3. September 2020: Notify impacted employees of the changes including retirees
   4. October 2020: Open Enrollment begins
   5. November 2020: VEBA Participation Agreement must be signed by all groups
   6. January 2021: New plans in effect

**CALIFORNIA HEALTH AND SAFETY CODE SECTION 1373.96.**

Cite as: Cal. Health & Safety Code §1373.96.

(a)A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b)(1)The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract’s termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2)The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c)The health care service plan shall provide for the completion of covered services for the following conditions:

(1)An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2)A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3)A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4)A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5)The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6)Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract’s termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d)(1)The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider’s services beyond the contract termination date.

(2)Unless otherwise agreed by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e)(1)The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider’s services.

(2)Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f)The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g)If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h)This section shall not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(i)This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. This section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j)This section shall not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k)The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.

(l)The following definitions apply for the purposes of this section:

(1)“Individual provider” means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2)“Nonparticipating provider” means a provider who is not contracted with a health care service plan.

(3)“Provider” shall have the same meaning as set forth in subdivision (i) of Section 1345.

(4)“Provider group” means a medical group, independent practice association, or any other similar organization.