

NEW MEDICAL PLAN ARRANGEMENT: Frequently Asked Questions (FAQs) for Retirees and Beneficiaries Covered under County of Marin Medical Plans

GENERAL INFORMATION

1. **What is the purpose of this FAQ document?**

This document is a brief overview of the new benefit plan arrangement and new Anthem Blue Cross plan which will be effective with the 2012 plan year barring any unforeseen circumstances. This document does not include exclusions and limitations of benefits under the insurance companies' plans. If there is any discrepancy between this document and the insurance companies' Evidences of Coverage, the Evidences of Coverage prevail. This FAQ is a supplement to the enclosed announcement concerning the new medical plan design change and arrangement, effective January 1, 2012.

The FAQ is broken down between Kaiser and Anthem Blue Cross and will outline the following areas in addition to General Information:

KAISER

Continuity of Care
Emergency
Copayments
Traveling
Out-of-area Dependents
Plan Administration

ANTHEM BLUE CROSS

Continuity of Care
Emergency
Network of Providers and Fee Basis
Deductible
Out-of-pocket Maximum
Prescription Drugs
Preventive Benefits
Traveling and Out-of-state Coverage
Plan Administration

2. **Why is the County implementing a new benefit plan arrangement? Why are the plans changing?**

The current medical insurance plan structure is not sustainable over the long-term due to the high costs of the plans. For many years the County has explored options for more affordable medical plans for both active employees and retirees. There have been many forces driving the need to control these costs, as indicated in the announcement accompanying this FAQ. The County is able to make the change in benefits at this time as a result of successful agreement with employee unions and associations. Not only will the change in plans help contain costs, but it will also allow the continued offering of both a Preferred Provider Organization (PPO) Plan through Anthem Blue Cross as well as Health Maintenance Organization (HMO) Plans through Kaiser.

3. **When will the medical plan design change go into effect?**

Barring any unforeseen circumstances, the new medical benefit arrangement will be effective with the January 1, 2012 plan year.

4. If I have additional questions, to whom do I address them?

If you are a retiree, please e-mail your questions to one of the following individuals at the Marin County Employees' Retirement Association (MCERA):

Helen Moody, Assistant Administrator	hmoody@co.marin.ca.us
David Sousa, Benefits Supervisor	dsousa@co.marin.ca.us
Todd Miller, Post-retirement Benefits Team	tmiller2@co.marin.ca.us
Cookie Shamrock, Post-retirement Benefits Team	lshamrock@co.marin.ca.us

Or, you may contact any of the Retirement representatives at:

Marin County Employees' Retirement Association
1 McInnis Parkway, Suite 100
San Rafael, CA 94903-2764
(415) 473-6147
Website: <http://www.mcera.org>

5. I previously waived medical coverage for my spouse or other dependent. May I add my spouse or other dependent now?

No. You may only add a spouse or other dependent if you have a qualifying event and add the newly eligible individual within 31 days of the qualifying event.

6. What is a qualifying event as it relates to our health plans?

A qualifying event is a change in a retiree's personal life that may impact eligibility for benefits. Examples of qualifying events are the birth of a child, marriage, or divorce. If you have a qualifying event, enrollment must take place within 31 days of the event.

7. How much will I have to pay for the new plan?

Each plan cost is different. Retirees will receive all the plan rates in the official written notice to be sent in a subsequent mailing.

8. Is the amount that my former employer pays to subsidize my healthcare premiums being reduced?

No. The current employer policy regarding contributions towards healthcare premiums is not changing as a result of this medical plan redesign.

9. What is the new medical plan design change and arrangement?

The County currently offers six medical plans; there are two PPO plans and four HMO plans:

- Blue Cross Prudent Buyer Plus
- Blue Cross Prudent Buyer Classic
- Kaiser High
- Kaiser Low
- Kaiser Limited
- Kaiser Silver

(In addition, there are retirees enrolled in out of state Kaiser plans, which are Kaiser Northwest, Kaiser Hawaii and Kaiser Colorado.)

The new benefit plan arrangement will consist of three medical plans; one PPO plan and two HMO plans:

- Anthem Blue Cross PPO
- Kaiser Low
- Kaiser Silver

(In addition, there are retirees enrolled in out of state Kaiser plans, which are Kaiser Northwest, Kaiser Hawaii and Kaiser Colorado.)

10. Will I receive a new identification card as a result of the implementation of the new medical plan arrangement?

Receipt of a new identification card depends on the following:

- If you are currently enrolled in Kaiser and staying in the Kaiser plan, you will not receive a new identification card.
- If you are currently enrolled in Blue Cross and staying in the Blue Cross plan, you will receive a new identification card.
- If you are changing from Kaiser to Blue Cross, or vice versa, you will receive a new card reflecting the coverage change.

11. If I want to change medical plans will I need to complete a new enrollment form?

Completion of a new enrollment form depends on the following:

Kaiser to Kaiser

- If you are currently enrolled in Kaiser High, Low, or Limited and are changing to, or staying in, Kaiser Low, you will not need to complete a new enrollment form.
- If you are currently enrolled in Kaiser Silver and want to remain in Kaiser Silver, you will not need to complete a new enrollment form.
- If you are currently enrolled in Kaiser High, Low or Limited and are changing to Kaiser Silver, you will need to complete an enrollment form
- If you are currently enrolled in Kaiser Silver and are changing to Kaiser Low you will need to complete an enrollment form.

Kaiser to Blue Cross

- If you are currently enrolled in Kaiser High, Low, Limited or Silver and changing to Blue Cross, you will need to complete an enrollment form.

Blue Cross to Blue Cross

- If you are currently enrolled in Blue Cross and remaining in Blue Cross, you will not need to complete an enrollment form.

Blue Cross to Kaiser

- If you are currently enrolled in Blue Cross and changing to the Kaiser Low or Silver plan, you will need to complete an enrollment form.

12. If I change from Blue Cross to Kaiser and after this one time change event I want to go back to Blue Cross, am I allowed?

No. This is a one-time change event. However, if you subsequently move out of the Kaiser service area, you will be allowed to change your plan to Anthem Blue Cross. Your request must be received by MCERA within 31 days of your relocation.

13. If I change from Kaiser to Blue Cross due to moving out of the Kaiser service area, and then I move back to a Kaiser service area mid-year, will I be able to move back on to the Kaiser plan mid-year?

Yes, as long as the request to move back to the Kaiser plan is received by the MCERA within 31 days of your relocation.

14. What will happen if I do not select a new medical plan?

If the Retirement Department does not receive a new enrollment form from you by November 14, 2011, you will automatically be moved into the “default” plan which is the most similar to your existing plan. If you make no changes, the following will occur:

- If you are currently enrolled in Kaiser High, Low, or Limited, you will be moved into or kept in Kaiser Low.
- If you are currently enrolled in Kaiser Silver, you will remain in Kaiser Silver.
- If you are currently enrolled in Blue Cross, you will be moved into the new Anthem Blue Cross plan.

15. When do I need to make a decision by?

All changes must be received by the Retirement Department by 5:00 pm Monday November 14, 2011.

16. How do I find out if a particular prescription medication is covered by my new medical plan?

Representatives from Kaiser and Anthem Blue Cross will be available to answer individual and group questions at the session dates listed on the accompanying announcement. You may also visit the insurance carriers at the following websites:

- Kaiser: <https://www.kaiserpermanente.org>
- Anthem Blue Cross: <http://www.anthem.com/health-insurance/home/overview>

➡ KAISER HEALTH PLAN FAQs ⬅

CONTINUITY OF CARE

17. Are any covered services being eliminated under the new benefit plan arrangement?

No.

18. Will my benefits change if I'm in the middle of treatment (substance abuse, mental health, medical, maternity, etc.) when the new benefit plan arrangement is implemented?

Yes, your benefits will change on the effective date of coverage.

19. If so, how will they change?

Benefits will be paid at the new level of benefits under the new arrangement. For example, individuals currently covered under the Kaiser High plan do not pay a copay per doctor office visit, but under the Kaiser Low plan there is a \$5 doctor office visit copay. You will have to pay \$5 for a doctor office visit if you are in the Kaiser Low plan effective January 1, 2012.

EMERGENCY AND URGENT CARE

20. Is the current Kaiser Emergency Room benefit and copay the same on all of the County's current active and retiree Kaiser plans? If so, is it changing under the new benefit plan arrangement?

Yes, the current Kaiser Emergency Room copay and benefit are the same on all of the County's current Kaiser plans. The Kaiser Emergency Room benefit and copay are not changing under the new benefit plan arrangement.

21. How much is the Urgent Care copay under the Kaiser Low plan?

Urgent Care consultations and exams have a \$5 copay per visit under the Kaiser Low plan.

22. How much is the Urgent Care copay under the Kaiser Silver plan?

Urgent Care consultations and exams have a \$25 copay per visit under the Kaiser Silver plan.

CO-PAYMENTS**23. How are immunizations covered– for myself and separately for my children?**

Immunizations (including vaccines) administered in a Kaiser Medical Office are covered at no charge under both the Low and Silver plans.

24. Who approves the physical therapy benefit for me? Will I have to pay an office visit copay each time I have physical therapy?

Your primary care physician will coordinate the physical therapy visits. A copay applies for each visit.

25. Will I have to pay a \$5 copay per visit to my primary care physician and then another \$5 copay per visit to see the specialist under the Kaiser Low plan?

Yes.

26. What will I have to pay in the same situation under the Kaiser Silver plan?

You will pay a \$25 copay per visit to your primary care physician, and then another \$25 copay per visit to see the specialist under the Kaiser Silver Plan.

27. Will I have to pay a \$5 copay per visit to my primary care physician for each visit, and then another \$5 copay per visit to the allergy doctor, plus \$3 for each allergy injection and serum under the Kaiser Low plan?

Yes.

28. What will I have to pay in the same situation under the Silver plan?

You will pay a \$25 copay per visit to your primary care physician, a \$25 copay per visit to the allergy doctor, and \$3 copay for each allergy injection and serum.

29. What vision services are included in the Kaiser medical plans?

Kaiser vision services are not changing as a result of the new medical plan arrangement. In general, Kaiser covers routine preventive vision screenings and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses, as well as medically necessary services as outlined in the Evidence of Coverage Vision Plan section. This applies to all of the County's Kaiser plans, and a copay applies per doctor office visit.

30. How do I find out more about the Kaiser Low and Silver plans?

Details of the Kaiser Low and Silver plans are on the MCERA website in the current Kaiser Low and Kaiser Silver Evidences of Coverage.

TRAVELING**31. If I am enrolled in the County's Kaiser plan and I am traveling in Southern California, may I use Kaiser Southern California facilities without penalties?**

Yes, you may use Kaiser Southern California facilities without penalty. Please refer to the Kaiser Travel brochure on the MCERA website.

32. If yes, do I have to call for pre-approval before using Kaiser Southern California?

Please refer to the Kaiser Travel brochure on the MCERA website. Some services may require pre-approval.

OUT-OF-AREA DEPENDENTS**33. If I enroll in the County's Kaiser plan, or if I'm already enrolled in the County's Kaiser plan, what benefits will my child who is covered on my Kaiser plan and who is living out of the Kaiser service area have?**

Your child will have emergency services only.

34. I have a child who is living in Southern California. If I enroll in the County's Kaiser plan will that child have the same coverage as if she/he lived in Northern California? Is that coverage provided through Kaiser Southern California?

Your dependent, if visiting for 90 days or less, may be treated as a visiting member. If your dependent is visiting longer, the dependent in Southern California may be enrolled as an Inter-Regional member. While benefits may differ slightly from the home region, Kaiser's goal is to match the benefits as closely as possible.

PLAN ADMINISTRATION**35. Will I have a new Kaiser group number?**

Current group numbers used for the Low and Limited plans are being eliminated. Kaiser group number 463 will be used for the Low plan and all individuals currently enrolled in either Kaiser High or Limited will be transferred to group number 463 which will become the Low plan. If you elect the Silver Plan, your group number will be 603194.

36. Will I receive a new Evidence of Coverage and enrollment package from Kaiser?

Evidences of Coverage are not automatically sent out by the insurance company. Evidence of Coverage can be requested from Kaiser Member Services. In addition, Evidence of Coverage is available on MCERA's website.

➡ ANTHEM BLUE CROSS PLAN FAQs ⬅**CONTINUITY OF CARE****37. Are any covered services being eliminated under the new benefit plan arrangement?**

No.

38. Will my benefits change if I am in the middle of treatment (substance abuse, mental health, medical, maternity, etc.) when the new benefit plan arrangement is implemented?

Yes, your benefits will change on the effective date of coverage.

39. If so, how will they change?

Benefits will be paid at the new level of benefits under the new arrangement. For example, if you are being treated for an acute or chronic condition and are receiving Inpatient Services in-network that are being paid currently at 90%, the new plan arrangement will pay at 80%. All other approvals and authorizations will remain intact with the new plan.

EMERGENCY**40. How does the emergency benefit (\$500 deductible +\$50 deductible + 20%) work? If I am not admitted to an in-network hospital as a result of my trip the emergency room, do I have to pay the \$500 deductible plus the \$50 deductible plus the 20%?**

If you are NOT admitted, you will be responsible for paying the \$500 calendar year deductible (assuming that it hasn't already been met on previous claims) plus the \$50 emergency room deductible and be responsible for 20% of the remaining eligible charges.

41. How does the emergency benefit work if I am admitted to the hospital following my trip to the emergency room? Are both the \$500 and \$50 deductibles waived?

If you ARE admitted to the hospital and you have not satisfied the \$500 deductible, then you will pay the \$500 calendar year deductible (assuming that it has not already been met on previous claims), plus 20% of the remaining eligible charges. The \$50 emergency room deductible will be waived.

NETWORK OF PROVIDERS AND FEE BASIS**42. Does the new Anthem Blue Cross PPO plan have the same network of doctors and hospitals that are in the County's current Blue Cross plans?**

Yes, this will remain unchanged. However, please see the Prescription Drug section in this FAQ for a change relative to the Specialty Drug network.

43. What is the basis of payment to providers in the new Anthem Blue Cross plan?

The new Anthem Blue Cross PPO plan reimburses in-network providers based on their Negotiated fee and reimburses out-of-network providers based on Customary and Reasonable fees. The Customary and Reasonable charge is determined by Anthem Blue Cross annually and is a charge which falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

44. What are the new co-insurance amounts that Anthem Blue Cross will pay under the new Anthem Blue Cross plan?

Under the new Anthem Blue Cross plan the co-insurance for in-network providers is 80% of their PPO Negotiated fee; the co-insurance for non-network providers is 60% of Customary and Reasonable fees.

45. Please provide an example of how the new Anthem Blue Cross plan will pay for an in-network provider as compared to a non-network provider, and how that compares to the current Blue Cross Prudent Buyer Classic plan.

Illustrative Claim Payment – Example Service – NOT an Office Visit (1)	Current Plan: Prudent Buyer Classic PPO		New Plan: Anthem Blue Cross PPO	
	Network	Non-Network	Network	Non-Network
Assumes deductibles are satisfied with only the coinsurance applicable				
Provider’s Billed Charge	\$500.00	\$500.00	\$500.00	\$500.00
Anthem Blue Cross Fee Basis	PPO Negotiated Fee	Fee Schedule	PPO Negotiated Fee	Customary & Reasonable Charge
Negotiated Fee	\$250.00		\$250.00	
Schedule Fee		\$140.00		
Customary and Reasonable Fee				\$400
Co-insurance				
Blue Cross	90%	90%	80%	60%
BC Pays (see note below)	\$225.00	\$126.00	\$200.00	\$240.00
Provider Write-off	(\$250.00)		(\$250.00)	
Employee Co-insurance Amount	\$25.00 10%	\$14.00 10%	\$50.00 20%	\$160.00 40%
Difference between Billed Charge & Fee Basis Amount is EE Responsibility	\$0	\$360.00	\$0	\$100.00
Total Patient Balance Due (EE pays coinsurance + amount over BC Fee Basis)	\$25.00	\$374.00	\$50.00	\$260.00
Patient Pays as a % of Billed Charges	5%	75%	10%	52%
(1) New Anthem Blue Cross PPO plan has a \$20 Office Visit Copay: The copay applies only to the visit itself. The coinsurance applies to any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.				

46. Please provide an example of how the new Anthem Blue Cross plan will pay for an in-network provider as compared to a non-network provider, and how that compares to the current Blue Cross Prudent Buyer Plus plan.

Illustrative Claim Payment – Example Service – NOT an Office Visit (1)	Current Plan: Prudent Buyer Plus PPO		New Plan: Anthem Blue Cross PPO	
	Network	Non-Network	Network	Non-Network
Assumes deductibles are satisfied with only the coinsurance applicable				
Provider’s Billed Charge	\$500.00	\$500.00	\$500.00	\$500.00
Anthem Blue Cross Fee Basis	PPO Negotiated Fee	Customary & Reasonable Charge	PPO Negotiated Fee	Customary & Reasonable Charge
Negotiated Fee	\$250.00		\$250.00	
Schedule Fee				
Customary and Reasonable Fee		\$400		\$400
Co-insurance				
Blue Cross	90%	90%	80%	60%
BC Pays (see note below)	\$225.00	\$360.00	\$200.00	\$240.00
Provider Write-off	(\$250.00)		(\$250.00)	
Employee Co-insurance Amount	\$25.00 10%	\$40.00 10%	\$50.00 20%	\$160.00 40%
Difference between Billed Charge & Fee Basis Amount is EE Responsibility	\$0	\$100.00	\$0	\$100.00
Total Patient Balance Due (EE pays coinsurance + amount over BC Fee Basis)	\$25.00	\$140.00	\$50.00	\$260.00
Patient Pays as a % of Billed Charges	5%	28%	10%	52%
(1) New Anthem Blue Cross PPO plan has a \$20 Office Visit Copay: The copay applies only to the visit itself. The coinsurance applies to any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.				

47. How do I find an in-network provider in California?

Follow these steps to find an in-network provider using Anthem Blue Cross' online directory:

- Visit <http://www.Anthem.com/ca>
- Click "Find a Doctor" and click the "Go" button
- Click "Medical Doctors – California"
- Under the Existing Members section, enter your member number and click the "Next" button, or click the "Next" button in the New Member & Visitor section
- After selecting your desired provider information from the drop down menus and/or entering your location, a list of doctors and/or facilities that match your search criteria will be displayed.

DEDUCTIBLE**48. What is the deductible increasing to: is it \$500 or \$1,000?**

The calendar year deductible on the Anthem Blue Cross PPO plan is \$500 per person with a calendar year maximum family deductible of \$1,000. The family deductible may be satisfied by a combination of family members contributing to it. For example, in a family of 4:

Each member could meet \$250, or

One member could meet the \$500 deductible and two other members of the family meet \$250 each, or

One member could meet \$300, another \$200, another \$400 and another \$100.

In other words, it does not matter how the family gets to \$1,000 in the calendar year.

49. Is there one deductible for network providers and a separate additional deductible for non-network providers?

No, the Individual/Family deductible of \$500/\$1,000 is the same for in-network and non-network providers.

50. Does this mean that if I go to a non-network physician and she charges me \$800 for a service, and her Customary and Reasonable charge is \$700, and 60% of \$700 is \$420, Anthem Blue Cross will apply \$420 to my \$500 per person deductible?

Yes.

OUT-OF-POCKET MAXIMUM**51. What is an annual out-of-pocket maximum?**

An out-of-pocket-maximum is the limit on the total coinsurance and deductible you will pay in any calendar year. Once the out-of-pocket-maximum is reached for a calendar year, the plan pays 100% of allowable covered expenses for the rest of the year.

The out-of-pocket-maximum for in-network providers is \$3,000 per individual and \$6,000 per family.

The out-of-pocket-maximum for out-of-network providers is \$15,000 per individual and \$45,000 per family.

52. How does the annual out-of-pocket maximum apply if I use a combination of in-network and non-network providers?

The out-of-pocket maximum for in-network and out-of-network providers does not cross-apply. The out-of-pocket maximums for in-network and out-of-network providers are satisfied separately.

- 53. Does the calendar year out-of-pocket individual and family maximum work the same way as the individual and family deductible in that, for example, multiple members may contribute to the \$6,000, but no one pay more than \$3,000 of services that apply?**

Yes.

PRESCRIPTION DRUGS

- 54. What is a Specialty Drug?**

Specialty drugs are a relatively new class of prescription medications that are commonly referred to as biopharmaceuticals. Specialty drugs are complex in both design and administration; most are self-injectable. Specialty drugs are used to treat conditions such as multiple sclerosis, cancer, HIV and certain forms of rheumatoid arthritis. These drugs can cost as much as \$200,000 per year and are costly to ship, store and administer. Insulin is not a specialty drug.

- 55. Please explain how the new prescription drug plan compares to the current prescription drug plan. I currently pay \$5 for each of the prescriptions I take; will I now have to pay \$30 for each prescription?**

The **current prescription drug benefit** is as follows (the following includes specialty drugs):

- **In-network**
 - ▶ Generic drugs are covered at a \$5 copayment through retail and \$10 copayment through mail-Order.
 - ▶ Brand Formulary drugs are covered at a \$10 copayment through retail and \$20 copayment through mail-order.
 - ▶ Non-Formulary drugs are covered at a \$20 copayment through retail and \$30 copayment through mail-order.
- **Out-of-network**
 - ▶ Member pays the above copays plus 50% of the remaining prescription drug maximum allowed amount and the cost in excess of the prescription drug maximum allowed amount.
 - ▶ Mail order is not covered out-of-network.

The **prescription drug benefit effective January 1, 2012**, is as follows (see the information below concerning specialty drugs):

- **In-network**
 - ▶ Generic drugs will still be covered at a \$5 copayment through retail and \$10 copayment through mail-order.
 - ▶ Brand Formulary drugs will now be covered at a \$15 copayment through retail and \$25 copayment through mail-order.
 - ▶ Non-Formulary drugs will now be at a \$30 copayment through retail and \$45 copayment through mail-order.

The new network for specialty drugs is CuraScript. Specialty drugs will be covered at the above copays when obtained through CuraScript.

In addition, to give members and their doctors enough time to contact CuraScript to set up the specialty prescriptions, the plan allows for members to get the first two fills of the specialty drug(s) at an in-network retail pharmacy. Members will be notified by a letter when they get a specialty medication filled at an in-network retail pharmacy the first two times. After which, the member will be responsible for the entire cost of the specialty drugs if they continue to use a pharmacy other than CuraScript. See Additional Information, below.

- **Out-of-network**
 - ▶ Mail order is not covered out-of-network.
 - ▶ For non-specialty covered drugs, member pays the copay plus 50% of the remaining prescription drug maximum allowed amount and the cost in excess of the prescription drug maximum allowed amount.

Specialty drugs are not covered out of network. See Additional Information, below.

Additional Information regarding specialty drugs and CuraScript

CuraScript is a full-service specialty pharmacy created to more effectively manage and monitor the distribution of specialty drugs. CuraScript offers a complete support program including a team of nurses, pharmacists and pharmacy care advocates who work closely with the prescribing doctor to help members taking specialty medications achieve the best possible outcomes from their treatments.

CuraScript can be reached at the numbers listed below. Care advocates are available to take calls Monday through Friday, from 5 a.m. to 7 p.m. Pacific Time. After-hours calls will be routed to the appropriate on-call staff.

- Phone: 1-800-870-6419
- Fax: 1-800-824-2642
- Client Advocacy Phone: 1-888-662-0944 (dedicated unit for provider inquiries)
- For speech and hearing impaired assistance (TDD/TTY): 1-800-221-6915

PREVENTIVE BENEFITS

56. What are the preventive care benefits?

Please refer to the Anthem Blue Cross Preventive Care Flyer.

57. How are immunizations covered – for myself and separately for my children?

Immunizations are covered at 100% if provided in-network under Preventive Care. Please refer to the Anthem Blue Cross Preventive Care Flyer.

TRAVELING AND OUT-OF-STATE COVERAGE

58. If I am covered under the new Anthem Blue Cross plan and I travel out-of-state, will I have in-network benefits if I see, for example, an Arizona Blue Cross in-network BlueCard provider?

Yes, individuals will have in-network benefits when seeing in-network BlueCard providers.

59. What is BlueCard and how is it different from in-network to non-network providers?

BlueCard is the network Anthem Blue Cross uses for non-California providers. If you live in California and are enrolled in the Anthem Blue Cross plan, you are a member of Anthem Blue Cross of California. For members who live outside of California, your plan is called “BlueCard PPO”. With BlueCard, you can access any Blue Cross/Blue Shield provider throughout the entire United States. By using an in-network provider you will have lower out-of-pocket costs. Please refer to the BlueCard flyer on the MCERA website.

60. Do the mechanics of the claims payment for BlueCard work the same as described in the illustrative claim payment examples in FAQs 45 and 46?

Yes.

61. How do I find an in-network provider when I'm out-of-state?

The Anthem Blue Cross website has an online directory that allows you to search for both doctors and health care facilities anywhere in the United States. You can even make your search more specific by choosing a specialty or entering the name of a particular doctor or a facility.

Follow these steps to find an in-network provider using Anthem Blue Cross' online directory:

- Visit <http://www.Anthem.com/ca>
- Click "Find a Doctor" and click the "Go" button
- Click "Medical Doctors – Nationwide"
- Under the Members section, enter the identification prefix "CNO" and click the "Next" button
- Enter your address or county information and click the "Next" button
- Use the drop down menu(s) to select your desired Provider Type and click the "Continue Search" button. A list of doctors and/or facilities that match your search criteria will be displayed.

62. My child is a college student living out-of-state. What Anthem Blue Cross benefits will she/he have if I'm enrolled in Blue Cross?

The Anthem Blue Cross PPO Plan is a national plan which provides medical coverage in all 50 states. The benefits available to your dependent children will be the same as the benefits available to you if you lived out-of-state.

63. I am not eligible for Medicare and I live out-of-state. Does this affect my benefits?

Retirees enrolled in the County's Anthem Blue Cross plan who are not eligible for Medicare, regardless of age or state have the same Blue Card benefits as an active employee without Medicare.

PLAN ADMINISTRATION**64. Will I receive a new identification card?**

Yes, Anthem Blue Cross members will receive a new identification card.

65. May I request additional copies of my identification card for my dependents?

You may request additional copies by calling the telephone number on the card you receive.

66. Is there a telephone number I can call after hours and on weekends for medical advice?

Yes, the Anthem Blue Cross Nurseline is available 24 hours a day, 7 days a week. The number for the Nurseline will be on the back of your Anthem Blue Cross identification card.

67. How will the new Anthem Blue Cross plan coordinate with Medicare?

The mechanics of coordination with Medicare are not changing. Information concerning Medicare coordination is being prepared and will be provided in a future communication.

Please send your questions concerning the upcoming plan changes to one of the individuals listed below so that we are sure to address them for you:

Helen Moody, Assistant Administrator

hmoody@co.marin.ca.us

David Sousa, Benefits Supervisor

dsousa@co.marin.ca.us

Todd Miller, Post-retirement Benefits Team

tmiller2@co.marin.ca.us

Cookie Shamrock, Post-retirement Benefits Team

lshamrock@co.marin.ca.us

Or, you may contact any of the Retirement representatives at:

Marin County Employees' Retirement Association
1 McInnis Parkway, Suite 100
San Rafael, CA 94903-2764
(415) 473-6147
Website: <http://www.mcera.org>

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