

Health Benefits Program Annual Report

November 1, 2016

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Executive Summary

Introduction

The California Public Employees' Retirement System (CalPERS) has developed the CalPERS Health Benefits Program Annual Report, as required by California Government Code Section 22866(a). This report is the first of an annual requirement to provide information about the CalPERS Health Benefits Program to the California Legislature and Director of Finance.

This report is a comprehensive look at the CalPERS Health Benefits Program for calendar year 2015, which contains, but is not limited to, information on the CalPERS Health Benefits Program membership including demographic characteristics, historic program enrollment figures, member health plan survey data relative to satisfaction and quality, population risk attributes, and the prevalence of chronic conditions.

Health plan information in the report includes the health plan's geographic coverage, health benefit designs offered to enrollees, health plan medical trend by aggregate service category, and health plan quality measures reported to CalPERS.

Additionally, the report provides CalPERS Health Benefits Program financial information including a reconciliation of past year premium increases or decreases, historic total program expenditures to provide health care, historic investment performance for the Public Employees' Contingency Reserve Fund and the Public Employees' Health Care Fund, and program staff and operating costs.

About CalPERS

CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. We purchase health benefits for approximately 1.4 million active and retired members and their families on behalf of the State of California (which includes the California State University) and approximately 1,200 public agencies and schools. CalPERS is projected to spend an estimated \$8.9 billion in 2017 to provide health benefits to our members. The CalPERS Health Benefits Program is primarily governed by the California Public Employees' Medical and Hospital Care Act (PEMHCA) and is also subject to various state and federal laws, regulations, and guidance.

Besides being a purchaser of public employee health benefits, CalPERS is also a public employee retirement system. CalPERS has a vested interest in the health of our members, not only during their tenure as employees, but also throughout retirement. This long-term relationship with active and retired members drives the comprehensive, quality health benefits we provide. For more than half a century, CalPERS has helped ensure that the employees who serve the people of California maintain their quality of life no matter what their age.

Section 1. General overview of the health benefits program

Section 1.A. Description of health plans and benefits provided, including essential and nonessential benefits as required by state and federal law, member expected out-of-pocket expenses, and actuarial value by metal tier as defined by federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

For 2015, CalPERS' Basic health plans included fully-insured and flex-funded health maintenance organization (HMO) plans, self-insured preferred provider organization (PPO) plans, and self-insured and fully-insured exclusive provider organization (EPO) plans. CalPERS' Medicare health plans included HMO Medicare Advantage plans and PPO Medicare Supplemental plans. CalPERS contracted with the following carriers to provide or administer these plans: Anthem Blue Cross of California, Blue Shield of California, Health Net, Kaiser Permanente, Sharp, and UnitedHealthcare. In addition, three Association (ASN) plans are available to members who belong to specific employee associations. The three ASN plans that are available to members include: California Association of Highway Patrolmen (CAHP), California Correctional Peace Officers Association (CCPOA), and Peace Officers Research Association of California (PORAC). CalPERS does not negotiate rates and is not responsible for the benefit administration of these three ASN plans.

State Law

CalPERS Basic HMO plans, regulated by the California Department of Managed Health Care (DMHC) under Health and Safety Code Section 1345(b), are required to cover medically necessary basic health care services, including:

- Physician services
- Hospital inpatient services and ambulatory care services
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services
- Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system
- Hospice care

CalPERS' PPO plans offer the same health plan benefits as our HMO plans.

Federal Law

CalPERS provide benefits in the Essential Health Benefits (EHB) categories below, except for pediatric dental and vision care. For state employees, dental and vision care for children and adults is administered separately through the California Department of Human Resources. Each public agency and school is responsible for their own dental and vision benefits.

Under the Affordable Care Act (ACA), EHBs are categorized as follows:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

Member Expected Out-of-Pocket Expenses

Member out-of-pocket costs include deductibles, coinsurance, co-payments, and other out-of-pocket costs as specified in the health plans' Evidence of Coverage (EOC) booklet. For example, a typical co-payment for a physician office visit for members enrolled in a Basic HMO plan is \$15 and \$20 for members enrolled in a Basic PPO plan. A typical deductible for members enrolled in a Basic PPO Plan is \$500 for individuals and \$1,000 for a family. In 2015, an average of \$348 was paid out-of-pocket for health care services and prescription drugs by CalPERS members. There was considerable variation in health care and prescription drug out-of-pocket costs among CalPERS members in 2015 based on whether the plan was an HMO or a PPO, and a Basic or Medicare health plan.

On average, a member in a Basic HMO plan paid \$143 in out-of-pocket costs, while a member in a Medicare HMO plan paid on average \$307. On average, a member in a Basic PPO plan paid \$948 in out-of-pocket costs, while a member in a Medicare PPO plan paid on average \$595.

Anticipated average out-of-pocket costs may vary due to benefit design or policy changes. An individual member may experience significantly different costs from the averages depending on frequency of doctor visits and the number of prescriptions filled each year.

Actuarial Value by Metal Tier

Actuarial Value (AV) is calculated as the percentage of total average costs for covered benefits that a health plan will cover. Under the ACA, a health insurance plan's AV indicates the average share of medical spending that is paid by the plan, as opposed to being paid out-of-pocket by the member.

The ACA stipulates that AV be calculated based on the provision of EHBs to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60-69 percent; silver, with an AV of 70-79 percent; gold, with an AV of 80-89 percent; and platinum, with an AV of 90 percent or above. CalPERS has determined that its Basic HMO plans fall in the platinum tier and its Basic PPO plans in the gold tier.

Section 1.B. Geographic coverage

CalPERS is the purchaser of health benefits for the State of California and approximately 1,200 public agencies and schools. As such, CalPERS members, both active and retired, are located across the state as well as outside of California.

CalPERS offers Basic and Medicare health plan options in all of California’s 58 counties. Additionally, CalPERS offers limited Basic and Medicare health plan options for members who live out-of-state.

Each year during the Open Enrollment process, CalPERS provides a matrix indicating which health plans are available in each of the 58 counties as well as out-of-state. This geographic coverage information assists members in selecting health plans available where they live or work. Please refer to the **2015 Health Benefit Summary (Appendix A)** for a comprehensive view of health plan availability by county.

Section 1.C. Historic enrollment information by Basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.

CalPERS is providing enrollment data for January 2015, April 2015, July 2015 and October 2015 (**Appendix B**). January 2015 data captures enrollment changes after the close of the annual open enrollment period. Changes outside of open enrollment are minimal and include newly hired employees and qualifying events to change coverage outside open enrollment (i.e. birth/adoption of a child, marriage, etc.). The tables in **Appendix B** present a "point-in-time" enrollment rather than "ever enrolled" data. Point-in-time numbers provide the best description of enrollment, since they show enrollment on a typical day.

The CalPERS total enrollment count includes state, public agencies and schools members, excluding Consolidated Omnibus Budget Reconciliation Act (COBRA) members. A breakdown of the quarterly enrollment count by plan name, health coverage type (Basic or Medicare), by program (state or public agencies and schools [contracting agencies]), by status (active or retired), and by subscriber and dependent tier (single, two-party or family) is presented in **Appendix B**.

The table below displays the total enrollment counts by Basic and Medicare as of January 1st for the years 2011 through 2015.

Total Enrollment					
	2011	2012	2013	2014	2015
Basic	1,156,073	1,162,021	1,164,118	1,155,007	1,155,133
Medicare	194,314	205,530	220,356	231,817	243,020
Total Enrollment	1,350,387	1,367,551	1,384,474	1,386,824	1,398,153

Section 1.D. Historic expenditures by Basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.

The total estimated CalPERS Health Benefits Program expenditure in 2015 was \$8.03 billion. Since actual membership fluctuates during any given month, the numbers presented are estimated expenditures, not actual. The estimated 2015 expenditure was based on “point in time” subscriber enrollments for each month of 2015 and the 2015 monthly published premium for each subscriber.

A breakdown of the estimated 2015 expenditures by plan name, health coverage type (Basic or Medicare), by program (state or public agencies and schools [contracting agencies]), by status (active or retired), and by subscriber and dependent tier (single, two-party or family) is presented in **Appendix C**.

The below table provides the estimated expenditures for the years 2011 through 2015.

Estimated Expenditures (in Millions)					
	2011	2012	2013	2014	2015
Basic Total*	\$5,929	\$6,156	\$6,678	\$6,864	\$7,045
Medicare Total*	825	867	833	858	975
Total Program*	\$6,754	\$7,022	\$7,511	\$7,722	\$8,020

*Estimates are determined by applying the corresponding year's premium amounts to the annualized January enrollment counts

Section 2. Reconciliation of premium increases or decreases from prior plan year and the reasons for those changes

Background

CalPERS health premiums are established based on estimated future health care costs. Following actuarial standards of practice, future health care costs are estimated using the most recent data available. The process for establishing the 2015 plan year premiums, which began in 2014, used data from 2013.

The Health Care Decision Support System (HCDSS) is the CalPERS data warehouse, containing more than ten years of de-identified claims data on all CalPERS Health Benefits Program enrollees. This data on the Health Benefits Program population enables CalPERS to analyze health plan performance, disease management programs, member utilization, and health care costs, including pharmacy costs. With the HCDSS and expert knowledge of the data contained within, CalPERS can continuously evaluate and advocate for the needs of the Health Benefits Program. The HCDSS has been proven to generate cost savings and other benefits to ensure that the best care and the best cost is delivered.

Health Premiums

CalPERS has been successful in moderating trend increases while still providing quality health care as a direct result of cost and quality conscious actions by the CalPERS Board of Administration (Board). The Board has mitigated medical trend increases through strategies such as promoting narrow hospital networks, adding narrow health plan networks, implementing ACA regulations, value based purchasing, integrated health models, competition, flex funding, and risk adjustment.

Past experience has shown that the following factors drive the premiums of CalPERS' health plans:

- Population age and gender
- Prevalence of chronic conditions
- Hospital utilization
- Pharmaceutical utilization
- Population geographic location

The future health care cost estimates used to set the rates are based on the data available during the rate development process. Actual costs are affected by numerous factors occurring in the time period between rate setting and the conclusion of the plan year. Some factors occurring in the intervening time may not be anticipated. CalPERS utilizes actuarial models to account for anticipated factors, but the models cannot predict the future with certainty. This uncertainty results in the year-over-year fluctuations in rates and premiums. Any variation between forecasted and actual costs will impact the percent change between years.

Fluctuations (increases and decreases) in premiums resulted from a number of factors including higher medical and pharmaceutical costs, and benefit design changes as described in the next section of this report. For 2015, premiums increased by 3.85 percent overall; over 570,000 members experienced a premium decrease.

After the HMO and PPO state premiums are established, regional factors are applied to the state premiums to determine regional health premiums for the public agencies and schools (contracting agencies). Tables reflecting premium increases or decreases between plan years 2014 and 2015 for state and contracting agency HMO, PPO, and ASN plans are presented in **Appendix D**. CalPERS does not negotiate rates and is not responsible for the benefit administration of ASNs.

Section 2.A. Description of benefit design and benefit changes, including prescription drug coverage, by plan. The description shall detail whether benefit changes were required by statutory mandate, federal law, or an exercise of the Board's discretion, the costs or savings of the benefit change, and the impact of how the changes fit into a broader strategy.

Benefit designs for CalPERS health plans including covered benefits and cost-sharing requirements are summarized in **Appendix A**. Each year CalPERS and its health plan carriers consider potential changes to benefit designs. Changes to health benefit designs can be the result of federal legislation, federal regulations, state legislation or state regulations, or direction by the Board. Certain components of the CalPERS Basic HMO plans are regulated by the DMHC, and subject to the Knox-Keene Health Care Service Plan Act of 1975.

In June 2014, the Board exercised its discretion and adopted the following five benefit changes for the 2015 health plan year:

- **High Performance Generic Step Therapy:**
The Board elected to add High Performance Generic Step Therapy to all HMO and PPO plans with CVS/caremark as their pharmacy benefit manager at a cost of 33 cents per subscriber per month (weighted average cost). This benefit encourages clinically appropriate prescribing at the lowest cost, without sacrificing clinical outcomes, by steering members to more cost effective first-line generics. An evaluation of the potential savings of the benefit change will be completed in 2017.
- **Acupuncture and Chiropractic Benefits:**
The Board elected to add Acupuncture and Chiropractic benefits to all CalPERS HMO plans at a cost of \$4.42 per subscriber per month (weighted average cost). This added benefit provided members with more options to manage pain and ensured a greater degree of compliance with the Public Employees' Medical and Hospital Care Act (PEMHCA, Government Code Section 22853).

- Removal of Centers of Excellence requirement for knee and hip replacements in Blue Shield HMO Plans:**
 The Board elected to remove the Centers of Excellence requirement for knee and hip replacements covered by the Blue Shield HMO plans. Removal of this requirement had no impact on rates. Centers of Excellence were replaced by a successful value-based purchasing design strategy for knee and hip replacements.
- Removal of outpatient hospital copay (\$250) for upper endoscopies, colonoscopies, cataract surgery, and knee injections in Blue Shield HMO Plans:**
 The Board elected to discontinue the outpatient hospital co-pay program for upper endoscopies, colonoscopies, cataract surgery, and knee injections covered by Blue Shield HMO plans at a cost of 24 cents per subscriber per month (weighted average cost). The program was replaced by a successful value-based purchasing design strategy for procedures performed at outpatient hospitals.
- Maximum Out-of-Pocket (MOOP) Limits for pharmacy benefits:**
 As permitted under the ACA, the Board implemented additional MOOP limits on pharmacy benefits beyond CalPERS' existing MOOP limits for medical benefits.

Section 2.B. Discussion of risk

Of the CalPERS subscriber population (not including spouses and dependents), approximately 59 percent were actively working and 41 percent were retired in the 2015 plan year. Over the past 10 years, there has been a slight increase in the percentage of public agency and schools (contracting agency) members receiving health benefits, but generally 60 percent of the CalPERS member population is associated with the State and 40 percent are associated with contracting agencies.

Members enrolled in CalPERS' health benefit plans are, on average, generally older and have a higher incidence of chronic conditions compared to other insured populations. The prevalence of diabetes, depression, coronary artery disease, heart failure, and asthma are all higher among members enrolled in CalPERS' health benefit plans when compared to other insured populations.

Approximately 25 percent of members enrolled in a CalPERS health benefit plan have an existing chronic condition that accounts for approximately 50 percent of all medical costs for the CalPERS Health Benefits Program. CalPERS defines a chronic condition as one of the following: Asthma, Coronary Artery Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Depression, Diabetes, and Hypertension. In the Basic plans, one in five members with a chronic condition accounts for 42 percent of spending, and in the Medicare plans, one in two members with a chronic condition accounts for 68 percent of spending.

The gender split among members enrolled in CalPERS health benefits plans is approximately 55 percent female, 45 percent male. While total CalPERS spending on females exceeds that of males, the difference in the share attributable to preventable chronic disease makes the amount of preventable costs larger among men than women. The age pattern of this disparity suggests that part of this difference is due to the portion of total spending on women due to childbirth.

In addition to the risk population analysis performed each year during the annual health premium rate development process, CalPERS periodically analyzes the risk profiles of state and contracting agencies to determine their comparative impact to overall risk to the Health Benefits Program. Staff uses age, gender, and diagnosis data from a 12-month period to determine the expected cost or utilization for individuals currently and in the future. State and contracting agency segments have similar risk profiles, and the Health Benefits Program as a whole is not greatly affected by the addition or departure of contracting agencies. For example, the addition of 149 contracting agencies representing 82,334 members between 2004 and 2011 increased CalPERS average health risk by merely 0.3 percent.

An additional consideration in terms of Health Benefits Program risk is the variance in health costs across California. Health insurers using standard actuarial practices calculate rates based on enrollment assumptions and anticipated changes in population risk, but also include regional factors. For example, an insurer might adjust its regional rate due to changes in negotiated provider charges and/or changes in medical management of some regions compared to others. Another factor could be new provider contracts that reflect different relative costs. Also, utilization of health services in a prior year can be a factor in counties with low membership because even a single catastrophic health event can temporarily skew costs. In larger populations, such events are distributed over more members, and therefore have less impact on overall cost factors.

CalPERS sets one statewide rate for state employees in order to mitigate this cost variance, but contracting agency rates are set by region and therefore regional risk dynamics affect contracting agencies much more than the state. Historically, prior to the 2005 adoption of regional pricing for contracting agency Basic premiums, the single statewide premium offered by each health plan carrier did not permit carriers to establish competitive rates in areas with lower healthcare costs. In 2004, the CalPERS Health Benefits Program lost approximately 37,000 contracting agency members in areas with lower healthcare costs, with continued losses projected. The implementation of regional pricing helped avert these threats, stabilizing contracting agency membership.

Section 2.C. Description of medical trend changes in aggregate service categories for each plan. The aggregate service categories used shall include the standard categories of information collected by the Board, consisting of the following: inpatient, emergency room, ambulatory surgery, office, ambulatory radiology, ambulatory lab, mental health and substance abuse, other professional, prescriptions, and all other service categories.

The overall cost trend for CalPERS HMO and PPO Basic health plans increased 7.2 percent in calendar year 2015, compared to 8.5 percent between calendar year 2013 and calendar year 2014. Trends are reported in the following service categories:

- Inpatient
- Emergency Room (ER)
- Hospital Outpatient (Hosp Outpatient)
- Ambulatory Surgery (AmbSx)
- Office Visit
- Laboratory (Lab)
- Radiology (Rad)
- Mental Health/Substance Abuse (MH/SA)
- Other Professional (Other Prof)
- Medical Prescriptions (Medical Rx)
- Prescription Drugs (Presc Rx)
- Preventative Care
- All Other

The 2015 trend in service category costs varied, with the largest contributions from the inpatient care, prescription drugs, and ambulatory surgery categories. Utilization rate¹ increases occurred in average length of stay and office visits, while all other service categories had a decreasing trend in utilization for calendar year 2015. See **Appendix E** for medical trends changes.

¹ Utilization rate is based on admits per 1,000.

Section 2.D. Reconciliation of past year premiums against actual enrollments, revenues, and accounts receivables

The information in this report was extracted from my|CalPERS on July 19, 2016, for the January through December 2015 plan year. The my|CalPERS platform is an information system that addresses business requirements of California's public pension system and public employee health benefits program. The data below originated at the subscriber enrollment level by coverage month, plan code, and health plan, and was summarized to reflect the amount owed to each health plan carrier. The my|CalPERS data is entered and/or validated by various sources, including the state, public agencies and schools, Health Benefits Officers, CalPERS staff, the State Controller's Office, and the health plan carriers.

Health Premium Management Report for Calendar Year 2015 (Dollars in Thousands)	
Health Plan Carriers	Health Premiums*
Anthem Blue Cross	\$2,214,905
Association Plans**	502,531
Blue Shield of California	2,108,860
Health Net	17,393
Kaiser Permanente	3,023,394
Sharp Health Plan	43,405
UnitedHealthcare Services, Inc.	112,858
Total	\$8,023,346
<p>*Health Premiums represent the total premium due to each health plan carrier from both the employer and the employee for the 2015 plan year based on enrollment as reflected in the my CalPERS system.</p> <p>**ASNs include CAHP, CCPOA, and PORAC. CalPERS does not negotiate rates and is not responsible for the benefit administration of ASN plans.</p>	

Section 3. Overall member health as reflected by data on chronic conditions

CalPERS employs several mechanisms to evaluate overall member health as reflected by data on chronic conditions; review of population demographics, analysis of member health, and claims data for chronic conditions.

A scan of the CalPERS member population indicates that 39 percent of CalPERS members had at least one chronic condition in 2015. Data indicates that 28 percent of active members and 62 percent of retired members had at least one chronic condition.

To further evaluate health of members, CalPERS reviews quarterly data submitted by the two largest carriers by enrollment, which account for roughly two-thirds of the CalPERS population. According to these carriers, CalPERS population has a higher incidence of chronic conditions compared to their general population.

In 2015, the seven most prevalent chronic conditions among CalPERS members were Hypertension, Diabetes, Depression, Asthma, Coronary Artery Disease, COPD, and Congestive Heart Failure. These conditions affect between 0.7 and 11.9 percent of the CalPERS population.

Based on CalPERS data warehouse for 2015:

- Hypertension affected 116,917 members (8.4 percent).
- Diabetes affected 131,986 members (9.4 percent).
- Depression was diagnosed in 64,596 members (4.6 percent).
- Asthma was diagnosed in 55,710 members (4 percent).
- Coronary artery disease was reported among 38,367 members (2.7 percent).
- COPD was diagnosed among 20,384 members (1.5 percent).
- Congestive heart failure was diagnosed among 9,275 members (0.7 percent).

The remaining chronic conditions among CalPERS members are diagnosed in less than 0.7 percent of the population. Note that CalPERS members may have more than one chronic condition and percentages reported are based on a total enrollment of 1,398,153 members.

Section 4. The impact of federal subsidies or contributions to the health care of members, including Medicare Part A, Part B, Part C, or Part D, low-income subsidies, or other federal program

Federal subsidies or contributions have a positive impact on the overall affordability of health care for CalPERS Medicare members. CalPERS does not currently receive any federal subsidies for its Basic plans. The premiums paid by CalPERS members and employers for Medicare health plans represent the cost of coverage above the federal contribution to Medicare.

A member must meet specific eligibility guidelines to enroll in a CalPERS Medicare health plan. CalPERS Medicare health plans coordinate with the Centers for Medicare and Medicaid Services (CMS) to help pay costs not covered by Medicare.

Medicare supplemental plans are mostly Fee-For-Service (FFS). CMS determines benefit designs and payment schedules for providers, and CalPERS typically pays whatever portion of the Medicare-approved services that are not paid by CMS (e.g., coinsurance and deductibles). The supplemental plan pays for prescription drugs, then CMS reimburses plans a portion of their costs through the Medicare Part D Employer Group Waiver Plan.

Medicare Advantage (MA) plans are mostly HMOs. CMS provides a subsidy to the carrier offering an MA plan based on an amount related to the average cost of health care for Medicare enrollees. This amount is adjusted by the health status of enrollees and the county in which the enrollee lives. Typically, this is not enough to cover the full cost of care for MA enrollees. The remaining portion is covered by the health plan. There is also a bonus for MA health plans that receive a four or five star quality rating from CMS. See Section 6.B of this report for more information regarding the Medicare star rating system. The MA plans typically have a prescription drug component that is comparable to Medicare Part D plans.

The Low Income Subsidy program is administered by CalPERS' carriers. CalPERS' role is to review the enrollee data and provide additional information to the carriers as needed. The carriers are responsible for collecting the subsidy from the federal government and distributing the subsidy to the member and/or employer.

⁷http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_failure.htm

Section 5. The cost of benefits beyond Medicare contained in the Board's Medicare supplemental plans

In 2015, CalPERS offered PERSCare, PERS Choice, and PERS Select PPO Supplemental plans. For most benefits under CalPERS' supplemental plans, the plans supplemented payments by Medicare for Medicare-approved services. However, the plans provided coverage for some benefits not covered by Medicare (e.g., acupuncture). Furthermore, the plans also provided coverage for medically necessary services and supplies when benefits under Medicare were exhausted or when charges for the services and supplies exceeded amounts covered by Medicare. The benefits beyond Medicare were:

PERSCare

- Acupuncture or Acupressure Services: Up to 20 visits per calendar year
- Blood Replacement: First three pints of blood disallowed by Medicare
- Christian Science Nurse or Practitioner: Outpatient treatment up to 24 sessions per calendar year
- Hearing Aid: Up to \$2,000 once every 24 months
- Hospital Services and Supplies (inpatient and outpatient): Services after a member exhausts the benefit period specified by Medicare
- Immunizations: Age appropriate routine immunizations
- Lancets: Lancets and lancing devices for the self-administration of blood tests
- Mental Health Services and Supplies (inpatient and outpatient): Services after a member exhausts the benefit period specified by Medicare
- Physical or Occupational Therapy: Services provided by a licensed provider for treatment of an acute condition upon referral by a physician
- Skilled Nursing Services: From the 101st thru the 365th day during each benefit period
- Speech Therapy: Up to a lifetime maximum of \$5,000 per member
- Smoking Cessation Programs: Up to \$100 per calendar year
- Vision Care: Vision benefits are administered by Vision Service Plan (VSP)

PERS Choice and PERS Select

- Acupuncture or Acupressure Services: A \$15 copayment will apply
- Hearing Aid: Up to \$1,000 every 36 months
- Smoking Cessation Programs: Up to \$100 per calendar year
- Vision Care: Vision benefits are administered by VSP

Aggregated Cost of Benefits Beyond Medicare

The table below shows an aggregated cost of claims paid for benefits beyond Medicare for PERSCare, PERS Choice, and PERS Select Medicare members in calendar year 2015.

2015 Benefits Beyond Medicare (Dollars in Thousands)	
Benefit	Aggregated Cost
Acupuncture or acupressure services	\$1,264
Blood replacement	12
Christian Science nurse or practitioner	0
Hearing aid	5,202
Hospital services and supplies (inpatient and outpatient)	96,476
Immunizations	121
Lancets	207
Mental Health services and supplies (inpatient and outpatient)	3,520
Physical or Occupational therapy	3,211
Skilled Nursing services	2,650
Speech therapy	18
Smoking cessation programs	3
Vision Care	128
Total	\$112,812

Section 6. Description of plan quality performance and member satisfaction, including, but not limited to the following:

Section 6.A. The Healthcare Effectiveness Data and Information Set (HEDIS®)

In the early 1990s, the National Committee for Quality Assurance (NCQA), a not-for-profit organization dedicated to improving health care quality, was entrusted the management of Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a set of healthcare performance measures that serves as a tool to gauge the performance of important dimensions of care and service.¹ The current HEDIS® set addresses preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value. It includes measures for high-burden diseases such as diabetes, asthma, heart disease and depression, as well as preventable hospitalizations and patient satisfaction.²

Employers, consultants, and consumers use HEDIS® data to help them choose the best health plan for their needs. HEDIS® measures are used by more than 90 percent of health plans in the United States to compare their plan performance and, more importantly, to make improvements in their quality of care and service. Health plans collect and publicly report data used in the HEDIS® measurement process. To ensure that this health plan data meets HEDIS® specifications, NCQA requires an independent auditor to examine each health plan's data and data analyses.² NCQA then publishes HEDIS® data for health plan carriers annually on its website.³ Other organizations such as Consumer Reports and the California Office of Patient Advocate disseminate HEDIS® data as well.

Large health plan carriers that contract with CalPERS are required to submit HEDIS® and HEDIS-like⁴ data specific to CalPERS members on an annual basis. Data analysis and reporting during the reporting year⁵ is based on data collected during the measurement year.⁶ This report includes HEDIS® and HEDIS-like data for reporting year 2016 based on data collected during measurement year 2015.

Appendix F shows HEDIS® and HEDIS-like data for CalPERS Basic members in CalPERS' HMO plans and for the self-funded PPO plans. This table does not include data from Health Net of California and Sharp Health Plan due to the small number of CalPERS members enrolled in these plans. Additionally, measures that are retired or not reportable (e.g., because they are "first year" measures) are excluded from the table.

Furthermore, the scores in **Appendix F** are not strictly comparable. For some of the measures (marked with asterisk), a PPO's score may be lower than an HMO'S score solely because of the way the data are collected, not necessarily because the PPO's actual performance is worse.

¹ <http://www.ncqa.org/hedis-quality-measurement/what-is-hedis>

² <http://www.ncqa.org/hedis-quality-measurement/performance-measurement>

³ <http://www.ncqa.org/report-cards/health-plans/health-insurance-plan-rankings/health-insurance-plan-rankings-2014-15>

⁴ True HEDIS measures must be audited. Unaudited CalPERS-specific measures that follow HEDIS specifications are classified as "HEDIS-like."

⁵ Year data are analyzed and reported

⁶ Year preceding the reporting year, during which the measures actually occurred

For those measures marked with an asterisk, HMOs gather additional information from patients' medical records. For all measures, PPOs and HMOs collect information from claims or other administrative data. Each year NCQA releases national average HEDIS® scores; however, those data were unavailable in time for this report.

Section 6.B. The Medicare star rating for Medicare supplemental plans

Medicare uses a Star Rating System to measure how well MA and prescription drug (Part D) plans perform¹. Medicare scores how well plans did in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score. Medicare assigns plans one overall star rating to summarize the plan's performance as a whole. Plans also get separate star ratings in each individual category reviewed. The overall star rating score provides a way to compare performance among several plans. Medicare star ratings are unavailable for CalPERS Medicare supplemental plans because they are neither MA plans nor Part D plans.

Section 6.C. The degree of satisfaction of members and annuitants with the health benefit plans and with the quality of the care provided, to the extent the board surveys participants

Each year, CalPERS conducts a Health Plan Member Survey. This survey assesses members' satisfaction with their health plan over the last 12 months. The most recent survey launched on March 14, 2016 and concluded on May 6, 2016. The survey asks members to rate certain aspects of their health experience using any number from 0 to 10 where 0 is the lowest possible rating and 10 is the highest possible rating. The overall rating is the average rating of total respondents on the 10-point scale. Graphical and statistical data are included in **Appendix G**. The following narrative summarizes those responses.

- When asked to rate satisfaction with their health plan, respondents enrolled in a Basic health plan gave an overall rating of 8.08, while respondents enrolled in a Medicare health plan gave an overall rating of 9.13.
- When asked to rate satisfaction with their personal doctor, respondents enrolled in a Basic health plan gave an overall rating of 8.66, while respondents enrolled in a Medicare health plan gave an overall rating of 9.07.
- When asked to rate satisfaction with the specialist they saw most often in the previous 12 months, respondents enrolled in a Basic health plan gave an overall rating of 8.56, while respondents enrolled in a Medicare health plan gave an overall rating of 9.07.
- When asked to rate satisfaction with pharmacy services, respondents enrolled in a Basic health plan gave an overall rating of 8.04, while respondents enrolled in a Medicare health plan gave an overall rating of 8.53.

¹<http://www.medicareinteractive.org/get-answers/overview-of-medicare-health-coverage-options/changing-medicare-health-coverage/the-five-star-rating-system-and-medicare-plan-enrollment>

Section 6.D. The level of accessibility to preferred providers for rural members who do not have access to health maintenance organizations

The 2015 CalPERS Health Plan Member Survey asks respondents to report their level of accessibility to care using a variety of multiple choice answers. Responses were filtered to show the level of accessibility to preferred providers for rural members who do not have access to an HMO plan for urgent care or after hours care. Graphical and statistical data are included in **Appendix G**. The following narrative summarizes those responses.

Of the Basic plan survey respondents, 211 responded as not having access to an HMO:

- The 211 respondents reside in 20 counties across California with only five respondents indicating that they went to the emergency room because there were not urgent care services within 15 miles/ 30 minutes of their homes. These respondents reside in Inyo, Modoc, Plumas, and Tehama counties.
- Of these respondents 11 provided responses when asked why it was not easy to get the after-hours care that they thought they needed. The 11 respondents reside in seven counties across California with only one indicating that the reason it was not easy to get the after-hours care they thought they needed was because the doctor's office or clinic that had after hours care was too far away. This respondent resides in Plumas County.

Of the Medicare plan survey respondents, 371 responded as not having access to an HMO:

- The 371 respondents reside in 20 counties across California with only 11 respondents indicating that they went to the emergency room because there were not urgent care services within 15 miles/ 30 minutes of their homes. These respondents reside in Amador, Calaveras, Inyo, Plumas, Shasta, and Siskiyou counties.
- Of these respondents 18 provided responses when asked why it was not easy to get the after-hours care that they thought they needed. The 18 respondents reside in six counties across California with only five indicating that the reason it was not easy to get the after-hours care they thought they needed was because the doctor's office or clinic that had after hours care was too far away. These respondents reside in Shasta, Siskiyou, and Trinity counties.

Section 6.E. Other applicable quality measurements collected by the Board as part of the Board's health plan contracts

The Board's health plan carrier contracts contain the following quality measurements:

2015 Health Plan Contracts Quality Measures	
Item	Health Plan Contractor Requirements
Behavioral Health Program	<p>Provide a behavioral health program for mental health and substance abuse designed to objectively monitor and evaluate the efficiency, appropriateness and quality of mental health and substance abuse care provided to plan members.</p> <p>Ensure that NCQA or URAC accreditation standards are maintained and that the program complies with applicable sections of federal and Knox-Keene Health Care Service Plan Act of 1975 mental health parity requirements. Upon CalPERS request, contractor will provide reports to CalPERS.</p>
CalPERS Staff Satisfaction Survey	Responsiveness and quality of administrative services as measured on an account management survey.
Evidence-Based Medicine (EBM)	Have clinical committees that establish clinical practice pathways and guidelines and use national sources to identify EBM practice guidelines (e.g., from the Agency for Healthcare Research and Quality or Milliman).
Leapfrog Group Initiatives Participation	Use best efforts to require its participating provider hospitals to undertake the safety and quality initiatives supported by the Leapfrog Group consisting of computer physician order entry, evidence-based hospital referral, and appropriate intensive care unit physician staffing.
Office of the Patient Advocate's Health Care Quality Report	Maintain a minimum of a two star rating for "Getting Care Easily" in the "Member Ratings" section from the Office of the Patient Advocate's Health Care Quality Report Card.
Performance Measures	Provide data on inpatient acute care quality and clinical quality.
Provider Network Quality Review	Conduct ongoing participating provider network reviews for quality and appropriate care (e.g., physician, hospital, and ancillary services) and report findings to CalPERS.

2015 Health Plan Contracts Quality Measures	
Item	Health Plan Contractor Requirements
Quality Management and Improvement	<p>Review, measure, and improve the quality of services provided and the clinical practices of its participating providers and provide reports to CalPERS.</p> <p>Maintain internal quality improvement policies and procedures designed to achieve significant, sustained, improvement in clinical care, plan member satisfaction, and health outcomes for plan members receiving capitated services.</p> <p>Perform an assessment of access to non-capitated services by plan members, including, but not limited to, the quality of outcomes and timeliness of these services; review its assessment with participating providers providing non-capitated services; and report semi-annually to CalPERS any clinical situation in which a question exists as to whether medically necessary care was delivered by those providers.</p>
Reporting and Public Regulatory Studies	<p>Submit to CalPERS a copy of any financial audit report and any public quality of care study or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., The Joint Commission, the National Committee for Quality Assurance [NCQA], or Utilization Review Accreditation Commission [URAC]).</p>

Section 7. A description of risk assessment and risk mitigation policy related to the Board’s self-funded and flex-funded plan offerings, including, but not limited to the following:

Section 7.A. Reserve levels and their adequacy to mitigate plan risk

As of December 31, 2015, the required actuarial reserve level for the PPO plans was \$525.8 million, and the total reserve level was \$597.0 million (i.e., \$71.2 million above the actuarial reserve level). In addition to establishing a conservative actuarial reserve requirement, staff has also assessed a higher total reserve level to account for worst-case scenarios, e.g., paying for Incurred But Not Reported (IBNR) medical claims due to a shutdown of all PPO plans or an unexpected health pandemic.

There are no actuarial reserves for CalPERS’ flex-funded HMO plans, but CalPERS does employ a risk mitigation strategy for these plans as discussed under Section 7.E.

Section 7.B. The expected change in reserve levels and the factors leading to this change

Actuarial staff forecasts the reserve at the end of every fiscal year. In addition, staff also assesses a worst-case scenario whereby the reserve is simultaneously intended to cover the IBNR reserve from a shutdown of all the plans, the RBC reserve (a reserve established to account for unforeseen pressures on premiums, such as a pandemic) for the PPO plans, and an increase in interest rates which would reduce the value of the reserve fund since it is invested in a high quality, fixed income securities with a duration of approximately five years. Based on an evaluation of the above, current reserves are adequate, and not expected to change.

Section 7.C. Policies to reduce excess reserves or rebuild inadequate reserves

CalPERS' policies to reduce excess reserves or rebuild inadequate reserves are as follows:

- If there are any plan specific excess reserve balances, either the subsequent year's plan premiums may be reduced, or excess reserves could be used to fund other health benefit plan programs such as wellness programs.
- If there are inadequate reserves for any plan, the subsequent year's premiums may be increased.

Section 7.D. Decisions to lower premiums with excess reserves

For 2015, CalPERS did not lower any plan's premiums with excess reserves.

Section 7.E. Use of reinsurance and other alternatives to maintaining reserves

The RBC requirement for the PPO plans is designed to provide adequate protection against adverse claims experience, thereby making reinsurance unnecessary.

As part of the annual rate development process, for each flex-funded HMO plan CalPERS' actuaries evaluate whether proposed premiums are sufficient to cover the costs of health benefits under a plan. This evaluation employs the following analysis:

CalPERS compares the projected current year per member per month (PMPM) amounts for Capitation and FFS against the negotiated Capitation and FFS amounts in the contract. If this comparison reveals CalPERS owes more than what it is being contractually collected for a plan, CalPERS then determines if there is existing money in the plan's account that is not already slated for any other purpose (e.g., risk adjustment), which can be used to fill the gap. If there are not any or enough funds in the plan's account to fill this gap, an amount is added to the plan's proposed premium to address the deficit.

As of December 31, 2015, the assets for the self-funded portion of CalPERS' HMO plans totaled \$70.0 million.

Section 8. Description and reconciliation of administrative expenditures, including but not limited to the following:

Administrative expenses include personnel services - a category of expenditure which includes payment of salaries and wages, the state's contribution to the Public Employees' Retirement Fund, insurance premiums for workers' compensation, the state's share of employees' health insurance and the state's share of Social Security. The information being provided below is for the 2015-16 fiscal year.

Section 8.A. Organization and staffing levels, including salaries, wages, and benefits.

CalPERS Health Benefits Program staffs 444.2 positions out of the total organization of 2,765 positions. The Health Benefits Program direct positions are located in the Customer Services and Support Branch and the Benefit Program Policy and Planning Branch. Enterprise Support Operation positions are throughout the organization, including the Operations and Technology Branch.

Staff Levels:	
Direct	253.6
Enterprise Support Operations	190.6
Total Staffing Levels	444.2
Personnel Services (Dollars in Thousands):	
Salary and Wages	\$27,901
Staff Benefits	14,163
Total Personnel Services	\$42,064

Section 8.B. Operating expenses and equipment expenditure items, including, but not limited to, internal and external consulting and intra-departmental transfers.

In addition to professional internal and external consulting services, operating expenses and equipment expenditure items include general expenses, printing, communication, travel, data processing, equipment and accessories for the equipment.

Operating Expenses & Equipment (Dollars in Thousands):	
Operating Expenses	\$6,853
Consultant and Professional Services – Internal	868
Consultant and Professional Services – External	6,634
Statewide Administrative Cost (Pro Rata)	3,328
Total Operating Expenses & Equipment	\$17,683

Section 8.C. Funding sources

The funding sources for the CalPERS Health Benefits Program are Public Employees' Contingency Reserve Fund (CRF) and the Public Employees' Health Care Fund (HCF).

Funding Sources (Dollars in Thousands):	
Public Employees' CRF	\$26,955
Public Employees' HCF	32,792
Total Funding Sources	\$59,747

Section 8.D. Investment strategies, historic investment performance, and expected investment returns of the Public Employees' CRF and the Public Employees' HCF.

Public Employees' CRF

Investment Strategy

The Public Employees' CRF is invested at the State Treasurer's Office in the Surplus Money Investment Fund (SMIF). The Pooled Money Investment Account (PMIA), of which SMIF is one part, shall be managed as follows:

- The pool will ensure the safety of the portfolio by investing in high quality securities and by maintaining a mix of securities that will provide reasonable assurance that no single investment or class of investments will have a disproportionate impact on the total portfolio.
- The pool will be managed to ensure that normal cash needs, as well as scheduled extraordinary cash needs can be met.
- Pooled investments and deposits shall be made in such a way as to realize the maximum return consistent with safe and prudent treasury management.

Historical Investment Performance (Net of Fees)			
Time Period	Allocation	Invested Assets as of 12/31/2015	Investment Performance
Quarter Ending December 31, 2015*	SMIF	\$ 569,606,032	0.36% quarterly yield

*Refer to **Appendix H** for historical quarterly yields of the SMIF.

Expected Investment Returns

The SMIF does not follow a benchmark. However, comparison of PMIA yields to the Federal Funds Rate and the S&P Government Investment Pool index are provided in **Appendix I**.

Public Employees' HCF

Investment Strategy

The Public Employees' HCF is invested at the State Treasurer's Office in the Surplus Money Investment Fund (SMIF) and with State Street Global Advisors (SSGA). The strategic objective of the Public Employees' HCF, as stated in the Investment Policy, is as follows:

- The HCF seeks to provide stability of principal, while avoiding large losses, enhance returns within prudent levels of risk, and maintain liquidity to meet cash needs.

Historical Investment Performance (Net of Fees)			
Time Period	Allocation	Invested Assets as of 12/31/2015	Investment Performance
Calendar Year End as of 12/31/2013	State Street Global Advisors (SSGA)	\$ 394,844,009	(0.93)% annual return
Calendar Year End as of 12/31/2014	U.S. Aggregate Bond Index Fund	\$ 420,730,348	6.55% annual return
Calendar Year End as of 12/31/2015		\$ 423,413,934	0.64% annual return
Quarter Ending December 31, 2015*	SMIF	\$ 116,911,825	0.36% quarterly yield

*Refer to **Appendix H** for historical quarterly yields.

Expected Investment Returns

The SSGA U.S. Aggregate Bond Index Fund is passively managed to follow the Barclays U.S. Aggregate Bond Index. While the 10-year historical annualized investment return for the index is 4.51%, past performance is not a guarantee of future results.

The SMIF does not follow a benchmark. However, comparison of PMIA yields to the Federal Funds Rate and the S&P Government Investment Pool index are provided in **Appendix I**.

Section 9. Changes in strategic direction and major policy initiatives

Below is description of changes in strategic direction and major policy initiatives for the 2015 health plan year. It includes content from the CalPERS Strategic Plan (Strategic Plan), CalPERS Business Plans, and CalPERS Finance and Administration Committee agenda items. These plans and agenda items are inter-related and complement each other focusing on cost, quality, and accessibility.

The 2012-17 Strategic Plan has three goals:

- Improve the sustainability of long-term pension and health benefits
- Create an organization that is high-performing, risk-intelligent, and innovative
- Engage in State and national policy development to increase effectiveness and long-term sustainability of our programs

In addition to the Strategic Plan, CalPERS produces an annual refresh of its Business Plans, which is the vehicle CalPERS uses to implement the Strategic Plan goals. The Business Plans describe the initiatives and include expected completion dates. Periodic agenda items related to business planning provide status updates.

The table below shows the status of health related Business Plan Initiatives during the 2015 plan year.

2015 Health Related Business Plan Initiatives		
Initiative Title	Description	Status
Employer Health Benefits	Assess the desire of contracting agencies for CalPERS to offer a more flexible health benefit design in order to attract and retain public agencies and school systems.	Completed
Population Health Management	Standardize health plans' approach to population health management across the continuum of care for active and retired members.	Completed
Integrated Health Models (IHM)	Standardize health plan contract language for IHM and IHM performance metrics. Develop an IHM roadmap and structural framework that would support a population health model.	Completed
Employer Wellness Partnerships	Continue partnership with SEIU Local 1000, California State Controller's Office, California State Treasurer's Office and California Department of Human Resources to implement the Worksite Wellness pilot project and motivate employers to encourage wellness for members.	Completed
Medicare-Only Health Contracting Alternatives	Explore feasibility of simplifying MA contract and, if directed by the Board, implement changes.	Completed
Employer Wellness Platform	Develop and implement a statewide wellness platform to engage employees, employers, and retirees in improving member health.	Deferred
Contracting Agency Outreach and Health Data Sharing	Engage employers in health policy discussions and identify ability to share health data with employers to develop workplace health improvement strategies.	Deferred
Complete Pilot to Improve Hospital Transition Care for Senior Members	Assess the specialized hospital transition care management program to improve quality and reduce hospital readmissions for PPO members with Long-Term Care policies.	New

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HBD-110: Supplemental Information

Appends the 2015 CalPERS Health Benefit Summary, CalPERS Publication HBD-110 (version dated August 2014.08.1)

There is an error in the 2015 Health Benefit Summary booklet. Refer to page 17 of the CalPERS Health Plan Benefit Comparison – Basic Plans section. For the PPO Basic Plans, the amounts reflected in the Maximum Calendar Year Co-pay for an individual (\$4,600) and family (\$9,200) are incorrect. The accurate amounts are the same as 2014 which are \$3,000 for an individual and \$6,000 for a family for PERS Select and PERS Choice, and \$2,000 for an individual and \$4,000 for a family for PERSCare.

See chart below with corrected rates highlighted in bold.

BENEFITS	PPO Basic Plans									
	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible										
Individual	N/A		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$300	\$600
Family	N/A		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$900	\$1,800
Maximum Calendar Year Co-pay (excluding pharmacy)										
Individual	\$2,000	N/A	\$3,000	N/A	\$3,000	N/A	\$2,000	N/A	\$3,300	\$3,300
Family	\$4,000	N/A	\$6,000	N/A	\$6,000	N/A	\$4,000	N/A	\$6,600	\$6,600
Hospital (including Mental Health and Substance Abuse)										
Deductible (per admission)	N/A		N/A		N/A		\$250		N/A	
Inpatient	10%	Varies	20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	
Outpatient Facility/ Surgery Services	\$50 (exceptions may apply)		20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	

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2015 Health Benefit Summary

Helping you make an informed choice
about your health plan



About CalPERS

CalPERS is the largest purchaser of public employee health benefits in California, and the second largest public purchaser in the nation after the federal government. Our program provides benefits to more than 1.3 million public employees, retirees, and their families.

Depending on where you reside or work, CalPERS offers active employees and retirees one or more types of health plans, which may include:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
(for members in certain California counties)

The CalPERS Board of Administration annually determines health plan availability, covered benefits, health premiums, and co-payments.

Whether you are working or retired, your employer or former employer makes monthly contributions toward your health premiums. The amount of this contribution varies. Your cost may depend on your employer or former employer's contribution to your premium, the length of your employment, and the health plan you choose. For monthly contribution amounts, active employees should contact their employer, State retirees should contact CalPERS, and contracting agency retirees should contact their former employer.

CalPERS Health Program Vision Statement

CalPERS will lead in the promotion of health and wellness of our members through best-in-class, data-driven, cost-effective, quality, and sustainable health benefit options for our members and employers.

We will engage our members, employers, and other stakeholders as active partners in this pursuit and be a leader for health care reform both in California and nationally.

About This Publication

The *2015 Health Benefit Summary* provides valuable information to help you make an informed choice about your health plan and health care providers. This publication compares covered services, co-payments, and benefits for each CalPERS health plan. It also provides information about plan availability by county and a chart summarizing important differences among health plan types.

You can use this information to determine which health plan offers the services you need at the cost that works for you. The 2015 health plan premiums are available at CalPERS On-Line at www.calpers.ca.gov. Check with your employer to find out how much they contribute toward your premium.

The *2015 Health Benefit Summary* provides only a general overview of certain benefits. It does not include details of all covered expenses or exclusions and limitations. Please refer to each health plan's *Evidence of Coverage* (EOC) booklet for the exact terms and conditions of coverage. Health plans mail EOCs to new members at the beginning of the year, and to existing members upon request. In case of a conflict between this summary and your health plan's EOC, the EOC establishes the benefits that will be provided.

This publication is to be used only in conjunction with the current year's rate schedule and EOCs. To obtain a copy of the rate schedule for any health plan, please go to CalPERS On-Line at www.calpers.ca.gov or contact CalPERS at 888 CalPERS (or 888-225-7377).

Other Health Publications

This publication is one of many resources CalPERS offers to help you choose and use your health plan. Others include:

- *Health Program Guide*: Describes Basic and Medicare health plan eligibility, enrollment, and choices
- *CalPERS Medicare Enrollment Guide*: Provides information about how Medicare works with your CalPERS health benefits

You can obtain the above publications and other information about your CalPERS health benefits through my|CalPERS at my.calpers.ca.gov or by calling CalPERS at 888 CalPERS (or 888-225-7377).

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CalPERS health plans are administered under the Public Employees’ Medical Hospital Care Act, a California State law. Nevertheless, as federal regulations related to the various elements of health care reform are released, CalPERS may need to modify benefits. For up-to-date information about your CalPERS health benefits and health care reform, please refer to the Health Benefits Program link on CalPERS On-Line at www.calpers.ca.gov.

Considering Your Health Plan Choices

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new CalPERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decision-making process. As you begin that process, the following are some questions you should ask:

- Do you prefer to receive your health care from an HMO or PPO? Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types.¹
- What are the costs (premiums, co-payments, deductibles, and out-of-pocket costs)? Beginning on page 16 of this booklet, you will find information about benefits, co-payments, and covered services. Visit CalPERS On-Line at www.calpers.ca.gov to find out what the premiums are for the various plans.
- Does the plan provide access to the doctors and hospitals you want? Contact health plans directly for this information. See the “Health Plan Directory” on page 14 of this booklet for health plan contact information.

¹ Note that in a few counties where access to HMOs is limited, a third option, Exclusive Provider Organization (EPO), is available. An EPO provides benefits similar to an HMO with some PPO features.

Understanding How CalPERS Health Plans Work

The following chart will help you understand some important differences among health plan types.

Features	HMO	PPO	EPO
Accessing health care providers	Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price	Gives you access to a network of health care providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers	Gives you access to the EPO network of health care providers (doctors, hospitals, labs, pharmacies, etc.)
Selecting a primary care physician (PCP)	Most HMOs require you to select a PCP who will work with you to manage your health care needs ¹	Does not require you to select a PCP	Does not require you to select a PCP
Seeing a specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval	Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services)	Encourages you to seek services from preferred providers to ensure your deductibles and co-payments are counted toward your calendar year out-of-pocket maximums ² Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill ³	Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the EPO's provider network without a referral from the health plan (except for emergency and urgent care services)
Paying for services	Requires you to make a small co-payment for most services	Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider	Requires you to make a small co-payment for most services

¹ Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.

² Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services.

³ Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or co-payments, plus any amount in excess of the allowed amount.

CalPERS Health Plan Choices

Depending on where you reside or work, your Basic and Medicare health plan options may include the following:

Basic EPO & HMO Health Plans	Basic PPO Health Plans	Supplement to Medicare EPO & HMO Health Plans	Supplement to Medicare PPO Health Plans	HMO Medicare Managed Care Plans (Medicare Advantage)	Out of State Plan Choices	
Anthem Blue Cross EPO	California Association of Highway Patrolmen (CAHP) Health Plan ¹ PERS Select PERS Choice PERSCare Peace Officers Research Association of California (PORAC) Police and Fire Health Plan ¹	Blue Shield Access+	CAHP Health Plan ¹	Anthem Blue Cross Medicare Preferred	Kaiser Permanente (HMO)	
Anthem Blue Cross Select HMO		Blue Shield Access+ EPO	PERS Select	Anthem Blue Cross Senior Secure	PERS Choice (PPO)	
Anthem Blue Cross Traditional HMO		Blue Shield NetValue	PERS Choice	PERSCare	Blue Shield 65 Plus	PERSCare (PPO)
Blue Shield Access+		CCPOA Medical Plan ¹	PORAC Police and Fire Health Plan ¹	Health Net Seniority Plus	PORAC Police and Fire Health Plan (PPO) ¹	
Blue Shield Access+ EPO		Sharp Performance Plus		Kaiser Permanente Senior Advantage		
Blue Shield NetValue				United Healthcare Group Medicare Advantage		
California Correctional Peace Officers Association (CCPOA) Medical Plan ¹						
Health Net Salud y Más						
Health Net SmartCare						
Kaiser Permanente						
Sharp Performance Plus						
UnitedHealthcare SignatureValue Alliance						

Contacting a Health Plan

If you have a specific question about a plan's coverage, benefits, or participating providers, please contact the plan directly. See the "Health Plan Directory" on page 14 for health plan contact information.

¹ You must belong to the specific employee association and pay applicable dues to enroll in an Association Plan (CCPOA, CAHP or PORAC)

Choosing Your Doctor and Hospital

Once you choose a health plan, you should select a primary care physician. Except in the case of an emergency, the doctors you can use — and the medical groups and hospitals you will have access to — will depend on your choice of health plan.

Many people find their doctor by asking neighbors or co-workers for a doctor's name. Others receive referrals from doctors they already know. Still others simply select a physician from their health plan who happens to be nearby. You can also use the *Health Plan Chooser* tool (described on pages 10-11), which is available on the CalPERS website at www.calpers.ca.gov to find out which

plans include your doctor. Once you choose a doctor, call the doctor's office and ask if he or she is affiliated with the plan you are selecting and the hospital you prefer to use. Either way, you should confirm that the doctor is taking new patients in the plan you select.

If you need to be hospitalized, your health plan or medical group will have certain hospitals that you are able to use. If you prefer a particular hospital, you should make sure the health plan you select contracts with that hospital. See page 15 for a list of resources that can help you evaluate and select a doctor and hospital.

Enrolling in a Health Plan Using Your Residential or Work ZIP Code

Some of our health plans are available only in certain counties and/or ZIP Codes. As you consider your health plan choices, you should determine which health plans are available in the ZIP Code in which you are enrolling.

In general, if you are an active employee or a working CalPERS retiree, you may enroll in a health plan using either your residential or work ZIP Code. To enroll in a Medicare Advantage plan, you must use your residential address.

If you are a retired CalPERS member, you may select any health plan in your residential ZIP Code area. You cannot use the address of the CalPERS-covered employer from which you retired to establish ZIP Code eligibility.

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.

To determine if the health plan you are considering provides services where you reside or work, see the "Health Plan Availability by County" chart on the following page. You can also use the *Health Plan search by ZIP code*, which is available on the CalPERS website at www.calpers.ca.gov, to find out which plans are available in your area. If you have questions about plan availability or coverage, or wish to obtain a copy of the *Evidence of Coverage*, contact the health plans using the "Health Plan Directory" on page 14.

Health Plan Availability by County: Basic Plans

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may

also use our online service, the *Health Plan Search by ZIP Code*, available at www.calpers.ca.gov.

- Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+	Blue Shield Access+ EPO	Blue Shield NetValue	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance
Alameda		●	●	●			●	●			●	●	●		●
Alpine							●					●	●		
Amador							●				●	●	●		
Butte			●	●			●	●				●	●		
Calaveras							●					●	●		
Colusa					●		●					●	●		
Contra Costa		●	●	●		●	●	●			●	●	●		●
Del Norte	●						●					●	●		
El Dorado		●	●	●		●	●	●			●	●	●		
Fresno		●	●	●		●	●	●			●	●	●		●
Glenn			●	●			●	●				●	●		
Humboldt			●	●			●					●	●		
Imperial		●	●	●		●	●	●				●	●		
Inyo							●					●	●		
Kern		●	●	●		●	●	●	●		●	●	●		●
Kings			●	●		●	●	●			●	●	●		
Lake							●					●	●		
Lassen							●					●	●		
Los Angeles		●	●	●		●	●	●	●	●	●	●	●		●
Madera			●	●		●	●	●			●	●	●		●
Marin			●	●		●	●	●			●	●	●		
Mariposa				●			●	●			●	●	●		
Mendocino			●		●		●					●	●		
Merced		●	●	●			●	●				●	●		●
Modoc							●					●	●		
Mono							●					●	●		
Monterey	●						●					●	●		
Napa			●				●				●	●	●		
Nevada		●	●	●		●	●	●				●	●		
Orange		●	●	●		●	●	●	●	●	●	●	●		●

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+	Blue Shield Access+ EPO	Blue Shield Net Value	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERS Care	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance
Placer		•	•	•		•	•	•			•	•	•		•
Plumas							•					•	•		
Riverside		•	•	•		•	•	•	•	•	•	•	•		•
Sacramento		•	•	•		•	•	•			•	•	•		•
San Benito			•				•					•	•		
San Bernardino		•	•	•		•	•	•	•	•	•	•	•		•
San Diego				•		•	•	•	•	•	•	•	•	•	
San Francisco		•	•	•		•	•	•			•	•	•		•
San Joaquin		•	•	•		•	•	•			•	•	•		•
San Luis Obispo			•	•		•	•	•				•	•		
San Mateo			•	•		•	•	•			•	•	•		•
Santa Barbara			•	•			•	•				•	•		
Santa Clara		•	•	•		•	•	•			•	•	•		•
Santa Cruz		•	•	•		•	•	•				•	•		•
Shasta							•					•	•		
Sierra					•		•					•	•		
Siskiyou							•					•	•		
Solano			•	•			•	•			•	•	•		•
Sonoma			•	•		•	•	•			•	•	•		•
Stanislaus		•	•	•		•	•	•			•	•	•		•
Sutter							•				•	•	•		
Tehama							•					•	•		
Trinity							•					•	•		
Tulare		•	•	•			•	•			•	•	•		
Tuolumne							•					•	•		
Ventura		•	•	•		•	•	•			•	•	•		•
Yolo		•	•	•		•	•	•			•	•	•		•
Yuba							•				•	•	•		
Out-of-State											•	▲	•		

Health Plan Availability by County: Medicare Plans

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may

also use our online service, the *Health Plan Search by ZIP Code*, available at www.calpers.ca.gov.

- Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.

County	Anthem Blue Cross Medicare Preferred	Anthem Blue Cross Senior Secure	Blue Shield 65 Plus	Blue Shield Access+ Medicare Supplement	Blue Shield Access+ EPO Medicare Supplement	Blue Shield NetValue Medicare Supplement	CAHIP Medicare Supplement	CCPOA Medicare Supplement	Health Net Seniority Plus Medicare Advantage	Kaiser Permanente Senior Advantage	PERS Select, PERS Choice, & PERSCare Medicare Supplement	PORAC Medicare Supplement	Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance
Alameda	●			●			●	●		●	●	●		●
Alpine							●				●	●		
Amador							●			●	●	●		
Butte	●			●			●	●			●	●		
Calaveras							●				●	●		
Colusa				●	●		●				●	●		
Contra Costa	●		●	●		●	●	●		●	●	●		●
Del Norte							●				●	●		
El Dorado	●			●		●	●	●		●	●	●		
Fresno	●		●	●		●	●	●		●	●	●		●
Glenn	●			●			●	●			●	●		
Humboldt	●			●		●	●				●	●		
Imperial	●		●	●		●	●	●			●	●		
Inyo							●				●	●		
Kern		●	●	●		●	●	●	●	●	●	●		●
Kings	●			●		●	●	●		●	●	●		
Lake							●				●	●		
Lassen							●				●	●		
Los Angeles		●	●			●	●	●	●	●	●	●		●
Madera	●		●	●		●	●	●		●	●	●		●
Marin	●			●		●	●	●		●	●	●		
Mariposa				●			●	●		●	●	●		
Mendocino	●				●		●				●	●		
Merced	●			●			●	●			●	●		●
Modoc							●				●	●		
Mono							●				●	●		
Monterey	●						●				●	●		
Napa	●						●			●	●	●		
Nevada	●		●			●	●	●			●	●		
Orange		●	●			●	●	●	●	●	●	●		●

County	Anthem Blue Cross Medicare Preferred	Anthem Blue Cross Senior Secure	Blue Shield 65 Plus	Blue Shield Access+ Medicare Supplement	Blue Shield Access+ EPO Medicare Supplement	Blue Shield Net Value Medicare Supplement	CAHP Medicare Supplement	CCPOA Medicare Supplement	Health Net Seniority Plus Medicare Advantage	Kaiser Permanente Senior Advantage	PERS Select, PERS Choice, & PERS Care Medicare Supplement	PORAC Medicare Supplement	Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance
Placer	•			•		•	•	•		•	•	•		•
Plumas	•						•				•	•		
Riverside		•	•	•		•	•	•	•	•	•	•		•
Sacramento	•			•		•	•	•		•	•	•		•
San Benito	•						•				•	•		
San Bernardino		•	•	•		•	•	•	•	•	•	•		•
San Diego				•		•	•	•	•	•	•	•	•	
San Francisco	•		•			•	•	•		•	•	•		•
San Joaquin	•		•	•		•	•	•		•	•	•		•
San Luis Obispo	•		•			•	•	•			•	•		
San Mateo	•			•		•	•	•		•	•	•		•
Santa Barbara	•			•			•	•			•	•		
Santa Clara	•			•		•	•	•		•	•	•		•
Santa Cruz	•			•		•	•	•			•	•		•
Shasta	•						•				•	•		
Sierra	•				•		•				•	•		
Siskiyou	•						•				•	•		
Solano	•			•			•	•		•	•	•		•
Sonoma	•			•		•	•	•		•	•	•		•
Stanislaus	•			•		•	•	•		•	•	•		•
Sutter	•						•			•	•	•		
Tehama	•						•				•	•		
Trinity	•						•				•	•		
Tulare	•			•			•	•		•	•	•		
Tuolumne	•						•				•	•		
Ventura	•		•			•	•	•		•	•	•		•
Yolo	•			•		•	•	•		•	•	•		•
Yuba	•						•			•	•	•		
Out-of-State										•	▲	•		

Tools to Help You Choose Your Health Plan

This section provides a variety of information that can help you evaluate your health plan choices. Included here are details about using my|CalPERS, the *Health Plan Chooser*, and the *Health Plan Choice Worksheet*.

Accessing Health Plan Information with my|CalPERS

You can use my|CalPERS at my.calpers.ca.gov, our secure, personalized website, to get one-stop access to all of your current health plan information, including details about which family members are enrolled. You can also use it to search for other health plans that are available in your area,

access CalPERS Health Program forms, and find additional information about CalPERS health plans. If you are a **retiree**, CalPERS is your Health Benefits Officer. Retirees may change their health plan during Open Enrollment by calling CalPERS toll free at **888 CalPERS** (or 888-225-7377).

Comparing Your Options: Health Plan Chooser

The *Health Plan Chooser* (“The Chooser”) is an online tool that provides a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use tool, you can weigh plan benefits and costs, and view how the plans compare based on objective quality of care measures and patient experience.

The Chooser is available to help you make health plan decisions at any time. You can use it to:

- Find a new health plan during Open Enrollment.
- Select your primary care physician or find a new specialist.
- Evaluate your health plan options and estimate costs.
- Choose a health plan when your employer first begins offering the CalPERS Health Benefits Program.
- Review health plan options due to changes in your marital status or enrollment area.
- Explore health plan options because you are planning for retirement or have become Medicare eligible.

The Chooser takes you through five steps that provide you with key information about each health plan. At each step, you can rate the plans. When you finish, the Chooser gives you a Results Summary chart highlighting the plan(s) you rated as the best fit in each category. This chart allows you to easily determine which plan meets your needs.

Be sure to tell us what you think about the *Health Plan Chooser* by completing a survey located in the Chooser’s “Results” page.

The *Health Plan Chooser* provides customized help in selecting the health plan that is right for you and your family. You can find the *Health Plan Chooser* by visiting CalPERS On-Line at www.calpers.ca.gov. Select *Health Benefits* program under “Quick Links” and then find the *Health Plan Chooser* under the “Shortcuts” menu.

How to Use the Health Plan Chooser

 **Step 1. Estimate Your Costs**
Your out-of-pocket costs will differ from plan to plan depending on several factors, including how much your employer contributes toward your premium, how often you go to the doctor, and how many prescriptions you fill each year. A chronic illness (e.g., heart disease, asthma, diabetes) can also affect your out-of-pocket costs. When you enter specific information about these variables into the Chooser, you will receive an estimate of how much your out-of-pocket costs will be each year. (Remember that any dollar amounts indicated on the Chooser are estimates only.)

 **Step 2. Find a Physician**
Unless you moved recently, you probably already have a primary care physician. You can use the health plan links on the Chooser to see if your physician is in the health plan you are considering. If your physician is not in the plan you are considering or if you would like to change physicians, you can search for physicians in your area by name or by specialty.

 **Step 3. Review Quality of Care and Patient Experience Ratings**
The Chooser links you to important resources and information about health care quality and patient experience, and allows you to see how consumers rate their health plan's clinical performance. You can consider a plan's overall rating in providing recommended care in key areas such as diabetes, asthma, heart disease and lung disease.

 **Step 4. Evaluate Plan Features**
On the surface, you may think that all health plans are pretty much the same—but if you look more closely, you will find differences in several areas. The Chooser helps you identify the differences by allowing you to evaluate features in three categories:

- Help to Stay Healthy
- Medical Conditions
- How to Save Money

For example, if you smoke and would like to quit, you can find out what type of smoking cessation program each plan offers. If your child has asthma, you can find out about asthma management programs. If you fill multiple prescriptions each year, you can get helpful tips on how to save money on your medications.

 **Step 5. Compare Plan Costs and Covered Services**
This part of the Chooser provides a summary of your costs for doctor visits and hospital stays, deductibles (if applicable), and the yearly maximum for each plan. To see more detailed information about your cost for various services, select any of the plan names.

For more information about CalPERS health plans and access to the *Health Plan Chooser*, visit our website at www.calpers.ca.gov. To speak with someone at CalPERS about your health plan choices, call **888 CalPERS** (or **888-225-7377**).

Comparing Your Options: Health Plan Choice Worksheet

An alternative tool we provide to help you choose the best plan for yourself and your family is the *Health Plan Choice Worksheet*, which you can find on page 13 of this booklet. Like the Chooser, this worksheet can be used to compare factors such as cost, availability, benefits, and quality of care measures. Simply follow the steps listed in the left column

of the Worksheet. Several questions can be answered with a simple “yes” or “no,” while others will require you to insert information or call the health plan. Some of the information can be found at CalPERS On-Line at www.calpers.ca.gov. If you need assistance completing the form, contact CalPERS at 888 CalPERS (or 888-225-7377).

Health Plan Choice Worksheet

Plan name and phone numbers:								
Select the type of plan: <i>(circle choice)</i>	HMO	PPO	EPO	Assoc. Plan ¹	HMO	PPO	EPO	Assoc. Plan ¹
Step 1 – Cost								
Calculate your monthly cost. Enter the monthly premium (see current year’s rate schedule). Premium amounts will vary based on 1-party/2-party/family and Basic/Medicare.								
Enter your employer’s contribution. For contribution amounts, active members should contact their employer; retired members should contact CalPERS.								
Calculate your cost. Subtract your employer’s contribution from the monthly premium. If the total is \$0 or less, your cost is \$0.								
Step 2 – Availability								
Search available plans online. Use our online service, the Health Plan Search by Zip Code, at www.calpers.ca.gov to find out if the plan is available in your residential or work ZIP Code. You may also call the plan’s customer service center.								
Call the doctor’s office. Confirm that they contract with the plan and are accepting new patients. Ask what specialists are available and the hospitals with which they are affiliated.								
Step 3 – Comparisons								
How does the plan rate in quality of care measures? See page 15 to find out.								
Compare the benefits. See pages 16–31. CalPERS plans offer a standard package of benefits, but there are some differences: acupuncture, chiropractic, etc.								
Step 4 – Other								
Other considerations: Does the plan offer health education? Do you or your family have special medical needs? What services are available when you travel? Are the provider locations convenient?								
What changes are you planning in the upcoming year (e.g., retirement, transfer, move, etc.)?								
Other information								
Compare and select a plan.								

¹ You must belong to the specific employee association and pay applicable dues to enroll in the Association Plans.

Additional Resources

As a health care consumer, you have access to many resources, services, and tools that can help you find the right health plan, doctor, medical group, and hospital for yourself and your family.

Health Plan Directory

Following is contact information for the health plans. Contact your health plan with questions about: ID cards; verification of provider participation; service area boundaries (covered ZIP Codes); benefits, deductibles, limitations, exclusions; and *Evidence of Coverage* booklets.

Anthem Blue Cross¹

(855) 839-4524

Actives Member Services

(800) 225-2273

Senior Secure (HMO)

(855) 251-8825

Medicare Preferred (PPO)

www.anthem.com/ca/calpers/HMO

Health Net of California¹

(888) 926-4921

www.healthnet.com/calpers

CVS Caremark

Pharmacy Benefit Manager

(877) 542-0284

www.caremark.com/calpers

Peace Officers Research

Association of California (PORAC)

(800) 937-6722

www.porac.org

Sharp Health Plan²

(855) 995-5004

www.sharphealthplan.com/calpers

Blue Shield of California

(800) 334-5847

www.blueshieldca.com/calpers

Kaiser Permanente

(800) 464-4000

www.kp.org/calpers

UnitedHealthcare¹

(877) 359-3714

Actives Member Services

(888) 867-5581

Retiree Member Services

www.uhc.com/calpers

California Association of Highway Patrolmen (CAHP)

(800) 759-5758

www.theca hp.org

PERS Select,² PERS Choice,² PERSCare²

Administered by

Anthem Blue Cross

(877) 737-7776

www.anthem.com/ca/calpers

California Correctional Peace Officers Association (CCPOA)

Medical Plan

(800) 257-6213

www.ccpoabt f.org

¹ Pharmacy benefits administered by CVS Caremark for the Basic plan only.

² Pharmacy benefits administered by CVS Caremark for both Basic and Medicare plans.

Obtaining Health Care Quality Information

Following is a list of resources you can use to evaluate and select a doctor and hospital.

Hospitals

CalQualityCompare

www.CalQualityCompare.org

CalHospitalCompare is a standardized, universal performance report card for California hospitals that includes patient experience and clinical quality measures.

U.S. Department of Health and Human Services

www.hospitalcompare.hhs.gov

This site provides publicly-reported hospital quality information, including measures on heart attacks, pneumonia, heart failure, and surgery.

HealthGrades

www.healthgrades.com

HealthGrades uses data from Medicare and states to compare outcomes of care for common procedures.

The Leapfrog Group

www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

Doctors and Medical Groups

Medical Board of California

www.mbc.ca.gov

This is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Office of the Patient Advocate

www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs and medical groups in California.

Benefit Comparison Charts

The benefit comparison charts on pages 16–31 summarize the benefit information for each health plan. For more details, see each plan's *Evidence of Coverage* (EOC) booklet.

CalPERS Health Plan Benefit Comparison— Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA <i>(Association Plan)</i>	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
Calendar Year Deductible										
Individual	N/A			N/A			N/A	N/A		N/A
Family	N/A			N/A			N/A	N/A		N/A
Maximum Calendar Year Co-pay (excluding pharmacy)										
Individual	\$1,500			\$1,500			\$1,500	\$1,500		\$1,500
Family	\$3,000			\$3,000			\$4,500	\$3,000		\$3,000
Hospital (including Mental Health and Substance Abuse)										
Deductible (per admission)	N/A			N/A			N/A	N/A		N/A
Inpatient	No Charge			No Charge			\$100/admission	No Charge		No Charge
Outpatient Facility/Surgery Services	No Charge			No Charge			\$50	No Charge		\$15

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$300	\$600
N/A	N/A	N/A		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$900	\$1,800
\$1,500	\$1,500	\$2,000	N/A	\$3,000	N/A	\$3,000	N/A	\$2,000	N/A	\$3,300	\$3,300
\$3,000	\$3,000	\$4,000	N/A	\$6,000	N/A	\$6,000	N/A	\$4,000	N/A	\$6,600	\$6,600
N/A	N/A	N/A		N/A		N/A		\$250		N/A	
No Charge	No Charge	10%	Varies	20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	
No Charge	No Charge	\$50 (exceptions may apply)		20–30% (hospital tiers)	40%	20%	40%	10%	40%	10%	

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA <i>(Association Plan)</i>	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
Emergency Services										
Emergency Room Deductible		N/A			N/A		N/A	N/A		N/A
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)		\$50			\$50		\$75	\$50		\$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)		\$50			\$50		\$75	\$50		\$50
Physician Services (including Mental Health and Substance Abuse)										
Office Visits (co-pay for each service provided)		\$15			\$15		\$15	\$15		\$15
Inpatient Visits		No Charge			No Charge		No Charge	No Charge		No Charge
Outpatient Visits		\$15			\$15		\$15	\$15		\$15
Urgent Care Visits		\$15			\$15		\$15	\$15		\$15
Vision Exam/Screening		No Charge			No Charge		\$15	No Charge		No Charge
Surgery/Anesthesia		No Charge			No Charge		No Charge	No Charge		No Charge
Diagnostic X-Ray/Lab										
		No Charge			No Charge		No Charge	No Charge		No Charge

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		N/A	
\$50	\$50	\$50+10% (co-pay reduced to \$25 if admitted on an inpatient basis)		20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		10%	
\$50	\$50	\$50+10% (co-pay reduced to \$25 if admitted on an inpatient basis)	\$50+40%	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%	50% (for non-emergency services provided by hospital emergency room)	
\$15	\$15	\$15	40%	\$20	40%	\$20	40%	\$20	40%	\$20	10%
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%
\$15	\$15	10%	40%	\$20	40%	\$20	40%	\$20	40%	10%	10%
\$15	\$15	\$15	40%	\$20	40%	\$20	40%	\$20	40%	10%	10%
No Charge	No Charge	Not Covered		Not Covered		Not Covered		Not Covered		Not Covered	
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA <i>(Association Plan)</i>	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
Prescription Drugs										
Deductible	N/A			N/A			Brand Formulary: \$50 <i>(not to exceed \$150/family)</i>	N/A		N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50			Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50			Generic: \$10 Brand Formulary: \$25 Non- Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Brand: \$20
Retail Pharmacy Maintenance Medications filled after 2 nd fill <i>(i.e. a medication taken longer than 60 days)</i> (not to exceed 30-day supply)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$25 Non- Formulary: \$50	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100		N/A
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$20 Brand Formulary: \$50 Non- Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100		Generic: \$10 Brand: \$40 <i>(31-100 day supply)</i>
Mail order maximum co-payment per person per calendar year	\$1,000			\$1,000			N/A	\$1,000		N/A
Durable Medical Equipment										
	No Charge			No Charge			No Charge	No Charge		No Charge
Infertility Testing/Treatment										
	50% of Covered Charges			50% of Covered Charges			50% of Allowed Charges	50% of Covered Charges		50% of Covered Charges

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		N/A		N/A		N/A		N/A	
Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Single Source: \$20 Multi Source: \$25		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50 (not to exceed 34-day supply)		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 34-day supply)		N/A	
Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75 N/A	
\$1,000	\$1,000	N/A		\$1,000		\$1,000		\$1,000		N/A	
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	20%	20%
				(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment \$1,000 or more)			
50% of Covered Charges	50% of Covered Charges	Not Covered		Not Covered		Not Covered		Not Covered		50%	

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA <i>(Association Plan)</i>	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
Occupational / Physical / Speech Therapy										
Inpatient (hospital or skilled nursing facility)	No Charge			No Charge			No Charge	No Charge		No Charge
Outpatient (office and home visits)	\$15			\$15			No Charge	\$15		\$15
Diabetes Services										
Glucose monitors, test strips	No Charge			No Charge			No Charge	No Charge		No Charge
Self-management training	\$15			\$15			\$15	\$15		\$15
Acupuncture										
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			N/A	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic										
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15 exam (up to 20 visits) No Charge diagnostic services; chiropractic appliances (up to \$50)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
No Charge	No Charge	10%	40%	No Charge		No Charge		No Charge		10%	10%
\$15	\$15	10% (pre-certification required for more than 24 visits)	40%	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	20%		\$20	10%
No Charge	No Charge	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
\$15	\$15	\$20		\$20		\$20		\$20		\$20	
\$15/visit (combined 20 visits per calendar year)	\$15/visit (combined 20 visits per calendar year)	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	20% (acupuncture/chiropractic; combined 15 visits per calendar year)	40%	20% (acupuncture/chiropractic; combined 15 visits per calendar year)	40%	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	\$20 (10% for all other services)	10%
\$15/visit (up to 20 visits per calendar year)	\$15/visit (up to 20 visits per calendar year)	10% (acupuncture/chiropractic; combined 20 visits)	40%	20% (acupuncture/chiropractic; combined 15 visits)	40%	20% (acupuncture/chiropractic; combined 15 visits)	40%	10% (acupuncture/chiropractic; combined 20 visits)	40%	\$20/up to 20 visits	\$35/visit

CalPERS Health Plan Benefit Comparison— Medicare Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Medicare Plans							
	Anthem Blue Cross		65 Plus	Blue Shield		CCPOA Medicare Supplement <i>(Association Plan)</i>	Health Net Seniority Plus Medicare Advantage	Kaiser Permanente Senior Advantage
	Medicare Preferred	Senior Secure		Access+ /EPO Medicare Supplement	NetValue Medicare Supplement			
Calendar Year Deductible								
Individual	N/A			N/A		N/A	N/A	N/A
Family	N/A			N/A		N/A	N/A	N/A
Maximum Calendar Year Co-pay (excluding pharmacy)								
Individual	\$1,500		\$6,700	\$1,500		\$1,500	\$6,700	\$1,500
Family	\$3,000		N/A	\$3,000		\$4,500 (3 or more)	N/A	\$3,000
Hospital (including Mental Health and Substance Abuse)								
Inpatient	No Charge			No Charge		\$100/ admission	No Charge	No Charge
Outpatient Facility/ Surgery Services	No Charge			No Charge		No Charge	No Charge	\$10
Skilled Nursing Facility								
Medicare (up to 100 days/benefit period)	No Charge			No Charge		No Charge	No Charge	No Charge
Home Health Services								
Medicare	No Charge			No Charge		\$15/visit (up to 100 visits per calendar year)	No Charge	No Charge
Hospice								
Medicare	No Charge			No Charge		No Charge	No Charge	No Charge

EPO & HMO Medicare Plans		PPO Medicare Plans							
Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance	CAHP Medicare Supplement (Association Plan)	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
\$1,500	\$1,500	N/A	N/A	N/A	N/A	\$3,000	N/A	\$15,000 calendar year stop-loss	
\$3,000	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	
No Charge	No charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	
No Charge	No charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Medicare Plans							
	Anthem Blue Cross Medicare Preferred	Senior Secure	65 Plus	Blue Shield Access+/ EPO Medicare Supplement	NetValue Medicare Supplement	CCPOA Medicare Supplement (Association Plan)	Health Net Seniority Plus Medicare Advantage	Kaiser Permanente Senior Advantage
Emergency Services								
Medicare (waived if admitted or kept for observation)	\$50			\$50		No Charge	\$50	\$50
Ambulance Services								
Medicare	No Charge			No Charge		No Charge	No Charge	No Charge
Surgery/Anesthesia								
	No Charge			No Charge		No Charge	No Charge	No Charge inpatient; \$10 outpatient
Physician Services (including Mental Health and Substance Abuse)								
Office Visits	\$10			\$10		\$10	\$10	\$10
Inpatient Visits	No Charge			No Charge		No Charge	No Charge	No Charge
Outpatient Visits	\$10			\$10		\$10	\$10	\$10
Urgent Care Visits	\$25			\$25		\$10	\$25	\$25
Preventive Services	No Charge			No Charge		No Charge	No Charge	No Charge
Allergy Treatment	No Charge			No Charge		No Charge	No Charge	\$3 (for allergy injections)
Diagnostic X-Ray/Lab								
	No Charge			No Charge		No Charge	No Charge	No Charge
Durable Medical Equipment								
Medicare	No Charge			No Charge		No Charge	No Charge	No Charge

EPO & HMO Medicare Plans		PPO Medicare Plans							
Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance	CAHP Medicare Supplement <i>(Association Plan)</i>	PERS Select		PERS Choice		PERSCare		PORAC <i>(Association Plan)</i>
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
\$50	\$50	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge
\$10	\$10	\$10	No Charge		No Charge		No Charge		No Charge
No Charge	No charge	No Charge	No Charge		No Charge		No Charge		No Charge
\$10	\$10	No Charge	No Charge		No Charge		No Charge		No Charge
\$25	\$25	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge
No Charge	No Charge	No Charge	No Charge		No Charge		No Charge		No Charge

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Medicare Plans							
	Anthem Blue Cross		65 Plus	Blue Shield	NetValue	CCPOA	Health Net	Kaiser
	Medicare Preferred	Senior Secure		Access+/ EPO Medicare Supplement	Medicare Supplement	Medicare Supplement <i>(Association Plan)</i>	Seniority Plus Medicare Advantage	Permanente Senior Advantage
Prescription Drugs								
Deductible	N/A			N/A		N/A	N/A	N/A
Retail Pharmacy (not to exceed 30-day supply)	Select Generics: \$0 Generic: \$5 Preferred: \$20 Non-Preferred: \$50			Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$35	Generic: \$5 Preferred: \$20 Non-Preferred: \$50	Generic: \$5 Preferred: \$20
Retail Pharmacy Long-Term Prescription Medications filled after 2nd fill (i.e. 90-day supply)	Select Generics: \$0 Generic: \$15 Preferred: \$60 Non-Preferred: \$150			Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$5 Preferred: \$20 Non-Preferred: \$35	Generic: \$15 Preferred: \$60 Non-Preferred: \$150	N/A
Mail Order Pharmacy Program (not to exceed 90-day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100			Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$70	Generic: \$10 Preferred: \$40 Non-Preferred: \$100	Generic: \$10 Preferred: \$40 Non-Preferred: \$40 (31-100 day supply)
Mail order maximum co-payment per person per calendar year	\$1,000			\$1,000		N/A	\$1,000	N/A

EPO & HMO Medicare Plans		PPO Medicare Plans							
Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance	CAHP Medicare Supplement <i>(Association Plan)</i>	PERS Select		PERS Choice		PERSCare		PORAC <i>(Association Plan)</i>
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
N/A	N/A	N/A	N/A		N/A	N/A		\$100	
Generic: \$5 Preferred: \$20 Non-Preferred: \$50	Generic: \$5 Preferred: \$20 Non-Preferred: \$50	Generic: \$5 Single Source: \$20 Multi Source: \$25	Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50	Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$10 Preferred: \$25 Non-Preferred: \$45	
Generic: \$10 Preferred: \$40 Non-Preferred: \$100	Generic: \$10 Preferred: \$40 Non-Preferred: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 30 day supply)</i>		Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 30 day supply)</i>	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 34 day supply)</i>		N/A	
Generic: \$10 Preferred: \$40 Non-Preferred: \$100	Generic: \$10 Preferred: \$40 Non-Preferred: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 90 day supply)</i>		Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 90 day supply)</i>	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 <i>(not to exceed 90 day supply)</i>		Generic: \$20 Preferred: \$40 Non-Preferred: \$75	
\$1,000	\$1,000	N/A	\$1,000		\$1,000	\$1,000		N/A	

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Medicare Plans							
	Anthem Blue Cross Medicare Preferred	Senior Secure	65 Plus	Blue Shield Access+/EPO Medicare Supplement	NetValue Medicare Supplement	CCPOA Medicare Supplement (Association Plan)	Health Net Seniority Plus Medicare Advantage	Kaiser Permanente Senior Advantage
Occupational / Physical / Speech Therapy								
Inpatient (hospital or skilled nursing facility)	No Charge			No Charge		No Charge	No Charge	No Charge
Outpatient (office and home visits)	\$10			\$10		No Charge	\$10	\$10
Diabetes Services								
Glucose monitors, test strips	No Charge			No Charge		No Charge	No Charge	No Charge
Self-management training	\$10			\$10		\$10	\$10	\$10
Hearing Services								
Routine Hearing Exam	No Charge			No Charge		No Charge	\$10	\$10
Physician Services	\$10			\$10		\$15	\$10	\$10
Hearing Aids	\$1,000 max/36 months			\$1,000 max/36 months		\$500 max/member	\$1,000 max/36 months	\$1,000 max/36 months
Vision Care								
Vision Exam	\$10			\$10		\$10	\$10	\$10
Eyeglasses (following cataract surgery)	No Charge			No Charge		No Charge	No Charge	No Charge
Contact Lenses (following cataract surgery)	No Charge			No Charge		No Charge	No Charge	No Charge
More Benefits Beyond Medicare (Services covered beyond Medicare coverage)								
Acupuncture	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		N/A	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$10/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		\$15/visit (up to 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$10/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

EPO & HMO Medicare Plans		PPO Medicare Plans							
Sharp Performance Plus Medicare Supplement	UnitedHealthcare SignatureValue Alliance	CAHP Medicare Supplement <i>(Association Plan)</i>	PERS Select		PERS Choice		PERSCare		PORAC <i>(Association Plan)</i>
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
\$10	\$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
\$10	\$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	\$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%	
\$10	\$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%	
\$1,000 max/ 36 months	\$1,000 max/ 36 months	20% (\$1,000 max/ 36 months)	20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$2,000 max/24 months)	20% (\$900 max/ 36 months)		
\$10	\$10	N/A	N/A	N/A	N/A	N/A	20%		
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%		
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%		
\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	20%	\$15/visit (up to 20 visits per calendar year)	\$15/visit (up to 20 visits per calendar year)	20%	20%			
\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	20%	No Charge	No Charge	No Charge	No Charge	20%		

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Appendix B – Historic Enrollment Information

2015 Enrollment as of January 1 st			
Plan Name	Basic	Medicare	Total
HMO			
Anthem HMO Select	22,401	44	22,445
Anthem HMO Traditional	10,825	167	10,992
Blue Shield Access+	166,860	31,430	198,290
Blue Shield NetValue	147,275	7,139	154,414
Health Net Salud y Más	2,483	33	2,516
Health Net Smartcare	747	17	764
Kaiser	445,527	81,991	527,518
Kaiser Out-of-State	565	1,710	2,275
Sharp	7,733	87	7,820
UnitedHealthcare	19,238	446	19,684
PPO			
Anthem EPO - Del Norte	0	N/A	0
Anthem EPO - Monterey	1,418	N/A	1,418
PERS Choice	177,001	60,425	237,426
PERS Select	36,699	1,275	37,974
PERSCare	24,314	51,587	75,901
ASN			
California Association of Highway Patrolmen (CAHP)	28,247	4,142	32,389
California Correctional Peace Officers Association (CCPOA) North	9,341	327	9,668
CCPOA South	28,575	399	28,974
Peace Officers Research Association of California (PORAC)	25,884	1,801	27,685
Total	1,155,133	243,020	1,398,153
Program	Total		
State	824,168		
Contracting Agency	573,985		
Total	1,398,153		
Status	Total		
Active	967,650		
Retired	430,503		
Total	1,398,153		
Subscriber and Dependent Tier	Total		
Single	293,872		
Two-Party	378,685		
Family	725,596		
Total	1,398,153		

Appendix B – Historic Enrollment Information – Continued

2015 Enrollment as of April 1 st			
Plan Name	Basic	Medicare	Total
HMO			
Anthem HMO Select	22,938	49	22,987
Anthem HMO Traditional	11,298	166	11,464
Blue Shield Access+	165,009	31,891	196,900
Blue Shield NetValue	144,144	7,478	151,622
Health Net Salud y Más	2,625	37	2,662
Health Net Smartcare	828	18	846
Kaiser	448,571	83,083	531,654
Kaiser Out-of-State	545	1,725	2,270
Sharp	7,935	95	8,030
UnitedHealthcare	20,368	489	20,857
PPO			
Anthem EPO - Del Norte	48	N/A	48
Anthem EPO - Monterey	1,498	N/A	1,498
PERS Choice	175,572	61,221	236,793
PERS Select	36,389	1,329	37,718
PERSCare	25,287	51,565	76,852
ASN			
CAHP	28,043	4,164	32,207
CCPOA North	9,282	338	9,620
CCPOA South	28,682	407	29,089
PORAC	25,693	1,860	27,553
Total	1,154,755	245,915	1,400,670
Program	Total		
State	822,999		
Contracting Agency	577,671		
Total	1,400,670		
Status	Total		
Active	965,518		
Retired	435,152		
Total	1,400,670		
Subscriber and Dependent Tier	Total		
Single	295,674		
Two-Party	379,238		
Family	725,758		
Total	1,400,670		

Appendix B – Historic Enrollment Information – Continued

2015 Enrollment as of July 1 st			
Plan Name	Basic	Medicare	Total
HMO			
Anthem HMO Select	23,587	55	23,642
Anthem HMO Traditional	11,600	190	11,790
Blue Shield Access+	163,538	32,346	195,884
Blue Shield NetValue	142,841	7,797	150,638
Health Net Salud y Más	2,658	39	2,697
Health Net Smartcare	848	19	867
Kaiser	448,625	83,883	532,508
Kaiser Out-of-State	560	1,756	2,316
Sharp	7,984	110	8,094
UnitedHealthcare	20,853	517	21,370
PPO			
Anthem EPO - Del Norte	46	N/A	46
Anthem EPO - Monterey	1,587	N/A	1,587
PERS Choice	174,433	62,138	236,571
PERS Select	36,651	1,375	38,026
PERSCare	25,606	51,625	77,231
ASN			
CAHP	28,077	4,176	32,253
CCPOA North	9,294	353	9,647
CCPOA South	28,841	432	29,273
PORAC	25,583	1,908	27,491
Total	1,153,212	248,719	1,401,931
Program	Total		
State	825,239		
Contracting Agency	576,692		
Total	1,401,931		
Status	Total		
Active	966,053		
Retired	435,878		
Total	1,401,931		
Subscriber and Dependent Tier	Total		
Single	298,077		
Two-Party	380,220		
Family	723,634		
Total	1,401,931		

Appendix B – Historic Enrollment Information – Continued

2015 Enrollment as of October 1 st			
Plan Name	Basic	Medicare	Total
HMO			
Anthem HMO Select	24,591	77	24,668
Anthem HMO Traditional	12,116	205	12,321
Blue Shield Access+	161,877	32,720	194,597
Blue Shield NetValue	141,060	8,171	149,231
Health Net Salud y Más	2,782	37	2,819
Health Net Smartcare	918	21	939
Kaiser	451,859	85,165	537,024
Kaiser Out-of-State	568	1,770	2,338
Sharp	8,138	118	8,256
UnitedHealthcare	21,870	573	22,443
PPO			
Anthem EPO - Del Norte	48	N/A	48
Anthem EPO - Monterey	1,708	N/A	1,708
PERS Choice	173,750	63,138	236,888
PERS Select	36,868	1,425	38,293
PERSCare	26,339	51,826	78,165
ASN			
CAHP	28,097	4,184	32,281
CCPOA North	9,264	362	9,626
CCPOA South	29,062	450	29,512
PORAC	25,490	1,961	27,451
Total	1,156,405	252,203	1,408,608
Program	Total		
State	828,685		
Contracting Agency	579,923		
Total	1,408,608		
Status	Total		
Active	968,747		
Retired	439,861		
Total	1,408,608		
Subscriber and Dependent Tier	Total		
Single	301,495		
Two-Party	381,964		
Family	725,149		
Total	1,408,608		

Appendix C – Historic Expenditures

Estimated 2015 Expenditures (Dollars in Thousands)			
Health Plan	Basic	Medicare	Total
HMO			
Anthem Select	\$138,374	\$326	\$138,700
Anthem Traditional	83,444	1,008	84,452
Blue Shield Access+	1,084,123	136,379	1,220,502
Blue Shield NetValue	861,504	32,823	894,327
Health Net Salud y Más	12,237	123	12,360
Health Net SmartCare	4,898	64	4,962
Kaiser	2,713,433	297,402	3,010,835
Kaiser Out-of-State	5,660	8,192	13,852
Sharp	42,897	417	43,314
UnitedHealthcare	110,717	1,677	112,394
Subtotal	\$5,057,287	\$478,411	\$5,535,698
PPO			
Anthem EPO - Del Norte	\$192	\$3	\$195
Anthem EPO - Monterey	9,931	43	9,974
PERS Choice	1,096,068	252,606	1,348,674
PERS Select	214,666	5,572	220,238
PERSCare	187,624	228,699	416,323
Subtotal	\$1,508,481	\$486,923	\$1,995,404
ASN			
California Association of Highway Patrolmen	\$138,874	\$17,633	\$156,507
California Correctional Peace Officers Association - North	54,587	1,874	56,461
California Correctional Peace Officers Association - South	134,804	2,302	137,106
Peace Officers Research Association of California	143,156	9,147	152,303
Subtotal	\$471,421	\$30,956	\$502,377
Grand Total	\$7,037,189	\$996,290	\$8,033,479
Program	Total		
State	\$4,679,368		
Contracting Agency	3,354,111		
Total	\$8,033,479		
Status	Total		
Active	\$5,735,181		
Retired	2,298,298		
Total	\$8,033,479		
Subscriber and Dependent Tier	Total		
Single	\$1,932,700		
Two-Party	2,456,350		
Family	3,644,429		
Total	\$8,033,479		

Appendix D – Premium Increases or Decreases from Prior Plan Year

Table 1: 2014 and 2015 State Basic Premiums (HMO, PPO, and ASN)

Basic		2014			2015			Percent Change from 2014
		Single	2 Party	Family	Single	2 Party	Family	
HMO	Anthem Select	\$622.53	\$1,245.06	\$1,618.58	\$639.45	\$1,278.90	\$1,662.57	2.72%
	Anthem Traditional	670.36	1,340.72	1,742.94	727.34	1,454.68	1,891.08	8.50%
	Blue Shield Access+	655.02	1,310.04	1,703.05	718.16	1,436.32	1,867.22	9.64%
	Blue Shield NetValue	575.78	1,151.56	1,497.03	670.36	1,340.72	1,742.94	16.43%
	Health Net Salud y Más	515.87	1,031.74	1,341.26	535.97	1,071.94	1,393.52	3.90%
	Health Net SmartCare	632.38	1,264.76	1,644.19	671.47	1,342.94	1,745.82	6.18%
	Kaiser	661.61	1,323.22	1,720.19	633.04	1,266.08	1,645.90	-4.32%
	Kaiser Out-of-State	917.20	1,834.40	2,384.72	922.78	1,845.56	2,399.23	0.61%
	Sharp	562.14	1,124.28	1,461.56	586.38	1,172.76	1,524.59	4.31%
	UnitedHealthcare	652.08	1,304.16	1,695.41	642.40	1,284.80	1,670.24	-1.48%
PPO	Anthem EPO	670.36	1,340.72	1,742.94	640.45	1,280.90	1,665.17	-4.46%
	PERS Choice	645.53	1,287.06	1,673.18	640.45	1,280.90	1,665.17	-0.48%
	PERS Select	594.95	1,189.90	1,546.87	618.22	1,236.44	1,607.37	3.91%
	PERSCare	698.73	1,397.46	1,816.70	718.93	1,437.86	1,869.22	2.89%
ASN	CAHP	602.71	1,170.07	1,530.35	620.79	1,205.17	1,576.26	3.00%
	CCPOA North	647.19	1,296.69	1,750.51	681.33	1,365.26	1,843.13	5.29%
	CCPOA South	533.75	1,069.76	1,445.37	561.88	1,126.30	1,521.82	5.29%
	PORAC	534.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%

Appendix D – Premium Increases or Decreases from Prior Plan Year - Continued

Table 2: 2014 and 2015 State Medicare Premiums (HMO, PPO, and ASN)

Medicare		2014			2015			Percent Change from 2014
		Single	2 Party	Family	Single	2 Party	Family	
HMO	Anthem Blue Cross	\$341.12	\$682.24	\$1,023.36	\$445.38	\$890.76	\$1,336.14	30.56%
	Blue Shield	298.21	596.42	894.63	352.63	705.26	1,057.89	18.25%
	Health Net	261.24	522.48	783.72	276.85	553.70	830.55	5.98%
	Kaiser California	294.97	589.94	884.91	295.51	591.02	886.53	0.18%
	Kaiser Out-of-State	388.65	777.30	1,165.95	390.47	780.94	1,171.41	0.47%
	Sharp	306.51	613.02	919.53	327.66	655.32	982.98	6.90%
	UnitedHealthcare	193.33	386.66	579.99	267.41	534.82	802.23	38.32%
PPO	PERS Choice	307.23	614.46	921.69	339.47	678.94	1,018.41	10.49%
	PERS Select	307.23	614.46	921.69	339.47	678.94	1,018.41	10.49%
	PERSCare	327.36	654.72	982.08	368.76	737.52	1,106.28	12.65%
ASN	CAHP	372.00	688.00	874.00	372.00	688.00	874.00	0.00%
	CCPOA	407.54	816.65	1,221.20	447.79	897.61	1,342.41	9.90%
	PORAC	397.00	791.00	1,264.00	402.00	802.00	1,281.00	1.34%

Table 3: Total Percent Change for Basic and Medicare Combined

Total Change	3.85%
Total PPO Change from 2014	2.93%
Total HMO Change from 2014	4.04%
Total ASN Change from 2014	5.39%

Appendix D – Premium Increases or Decreases from Prior Plan Year - Continued

Table 4: 2014 and 2015 Regional Contracting Agencies Premiums Basic (HMO and PPO)

Basic		2014			2015			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates Bay Area								
Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba								
HMO	Anthem Select	\$657.33	\$1,314.66	\$1,709.06	\$662.41	\$1,324.82	\$1,722.27	0.77%
	Anthem Traditional	728.41	1,456.82	1,893.87	827.57	1,655.14	2,151.68	13.61%
	Blue Shield Access+	836.59	1,673.18	2,175.13	928.87	1,857.74	2,415.06	11.03%
	Blue Shield NetValue	704.01	1,408.02	1,830.43	870.60	1,741.20	2,263.56	23.66%
	Kaiser CA	742.72	1,485.44	1,931.07	714.45	1,428.90	1,857.57	-3.81%
	UnitedHealthcare	764.24	1,528.48	1,987.02	850.67	1,701.34	2,211.74	11.31%
PPO	PERS Choice	690.77	1,381.54	1,796.00	700.84	1,401.68	1,822.18	1.46%
	PERS Select	661.52	1,323.04	1,719.95	690.43	1,380.86	1,795.12	4.37%
	PERSCare	720.04	1,440.08	1,872.10	775.08	1,550.16	2,015.21	7.64%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%
Basic Premium Rates Sacramento Area								
El Dorado, Placer, Sacramento, and Yolo								
HMO	Anthem Select	\$750.27	\$1,500.54	\$1,950.70	\$811.14	\$1,622.28	\$2,108.96	8.11%
	Anthem Traditional	840.43	1,680.86	2,185.12	940.16	1,880.32	2,444.42	11.87%
	Blue Shield Access+	734.87	1,469.74	1,910.66	809.22	1,618.44	2,103.97	10.12%
	Blue Shield NetValue	618.39	1,236.78	1,607.81	758.45	1,516.90	1,971.97	22.65%
	Kaiser CA	681.59	1,363.18	1,772.13	660.96	1,321.92	1,718.50	-3.03%
	UnitedHealthcare	643.34	1,286.68	1,672.68	623.45	1,246.90	1,620.97	-3.09%
PPO	PERS Choice	665.99	1,331.98	1,731.57	679.26	1,358.52	1,766.08	1.99%
	PERS Select	637.85	1,275.70	1,658.41	669.16	1,338.32	1,739.82	4.91%
	PERSCare	694.26	1,388.52	1,805.08	751.21	1,502.42	1,953.15	8.20%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%
Basic Premium Rates Los Angeles Area								
Los Angeles, San Bernardino, and Ventura								
HMO	Anthem Select	\$475.86	\$951.72	\$1,237.24	\$493.40	\$986.80	\$1,282.84	3.69%
	Anthem Traditional	549.76	1,099.52	1,429.38	631.62	1,263.24	1,642.21	14.89%
	Blue Shield Access+	469.91	939.82	1,221.77	517.87	1,035.74	1,346.46	10.21%
	Blue Shield NetValue	395.50	791.00	1,028.30	485.41	970.82	1,262.07	22.73%
	Health Net Salud y Más	425.44	850.88	1,106.14	430.71	861.42	1,119.85	1.24%
	Health Net SmartCare	542.71	1,085.42	1,411.05	568.47	1,136.94	1,478.02	4.75%
	Kaiser CA	541.79	1,083.58	1,408.65	521.18	1,042.36	1,355.07	-3.80%
	UnitedHealthcare	487.76	975.52	1,268.18	458.74	917.48	1,192.72	-5.95%
PPO	PERS Choice	599.19	1,198.38	1,557.89	585.18	1,170.36	1,521.47	-2.34%
	PERS Select	573.83	1,147.66	1,491.96	576.49	1,152.98	1,498.87	0.46%
	PERSCare	624.59	1,249.18	1,623.93	647.11	1,294.22	1,682.49	3.61%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%

Appendix D – Premium Increases or Decreases from Prior Plan Year – Continued

Table 4: 2014 and 2015 Regional Contracting Agencies Premiums Basic (HMO and PPO) (continued)

Basic		2014			2015			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates Other Southern California								
Fresno, Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, and Tulare								
HMO	Anthem Select	\$536.99	\$1,073.98	\$1,396.17	\$653.97	\$1,307.94	\$1,700.32	21.78%
	Anthem Traditional	592.20	1,184.40	1,539.72	743.12	1,486.24	1,932.11	25.48%
	Blue Shield Access+	543.21	1,086.42	1,412.35	598.66	1,197.32	1,556.52	10.21%
	Blue Shield NetValue	457.17	914.34	1,188.64	561.09	1,122.18	1,458.83	22.73%
	Health Net Salud y Más	489.82	979.64	1,273.53	520.59	1,041.18	1,353.53	6.28%
	Health Net SmartCare	568.51	1,137.02	1,478.13	579.88	1,159.76	1,507.69	2.00%
	Kaiser CA	602.79	1,205.58	1,567.25	579.80	1,159.60	1,507.48	-3.81%
	Sharp	538.59	1,077.18	1,400.33	564.57	1,129.14	1,467.88	4.82%
	UnitedHealthcare	521.01	1,042.02	1,354.63	449.10	898.20	1,167.66	-13.80%
PPO	PERS Choice	612.25	1,224.50	1,591.85	594.40	1,188.80	1,545.44	-2.92%
	PERS Select	586.32	1,172.64	1,524.43	585.58	1,171.16	1,522.51	-0.13%
	PERSCare	638.22	1,276.44	1,659.37	657.32	1,314.64	1,709.03	2.99%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%
Basic Premium Rates Other Northern California								
Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne								
HMO	Anthem Select	\$706.20	\$1,412.40	\$1,836.12	\$728.65	\$1,457.30	\$1,894.49	3.18%
	Anthem Traditional	767.36	1,534.72	1,995.14	838.48	1,676.96	2,180.05	9.27%
	Blue Shield Access+	729.76	1,459.52	1,897.38	804.34	1,608.68	2,091.28	10.22%
	Blue Shield NetValue	614.13	1,228.26	1,596.74	753.82	1,507.64	1,959.93	22.75%
	Kaiser CA	745.30	1,490.60	1,937.78	716.98	1,433.96	1,864.15	-3.80%
	UnitedHealthcare	659.06	1,318.12	1,713.56	677.35	1,354.70	1,761.11	2.78%
PPO	Anthem EPO	767.36	1,534.72	1,995.14	656.08	1,312.16	1,705.81	-14.50%
	PERS Choice	641.08	1,282.16	1,666.81	656.08	1,312.16	1,705.81	2.34%
	PERS Select	613.99	1,227.98	1,596.37	646.35	1,292.70	1,680.51	5.27%
	PERSCare	668.27	1,336.54	1,737.50	725.54	1,451.08	1,886.40	8.57%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%
Basic Premium Rates Out of State								
HMO	Kaiser	\$917.20	\$1,834.40	\$2,384.72	\$922.78	\$1,845.56	\$2,399.23	0.61%
PPO	PERS Choice	706.40	1,412.80	1,836.64	653.58	1,307.16	1,699.31	-7.48%
	PERSCare	736.32	1,472.64	1,914.43	722.74	1,445.48	1,879.12	-1.84%
ASN	PORAC	634.00	1,186.00	1,507.00	675.00	1,292.00	1,642.00	8.70%

Appendix D – Premium Increases or Decreases from Prior Plan Year – Continued

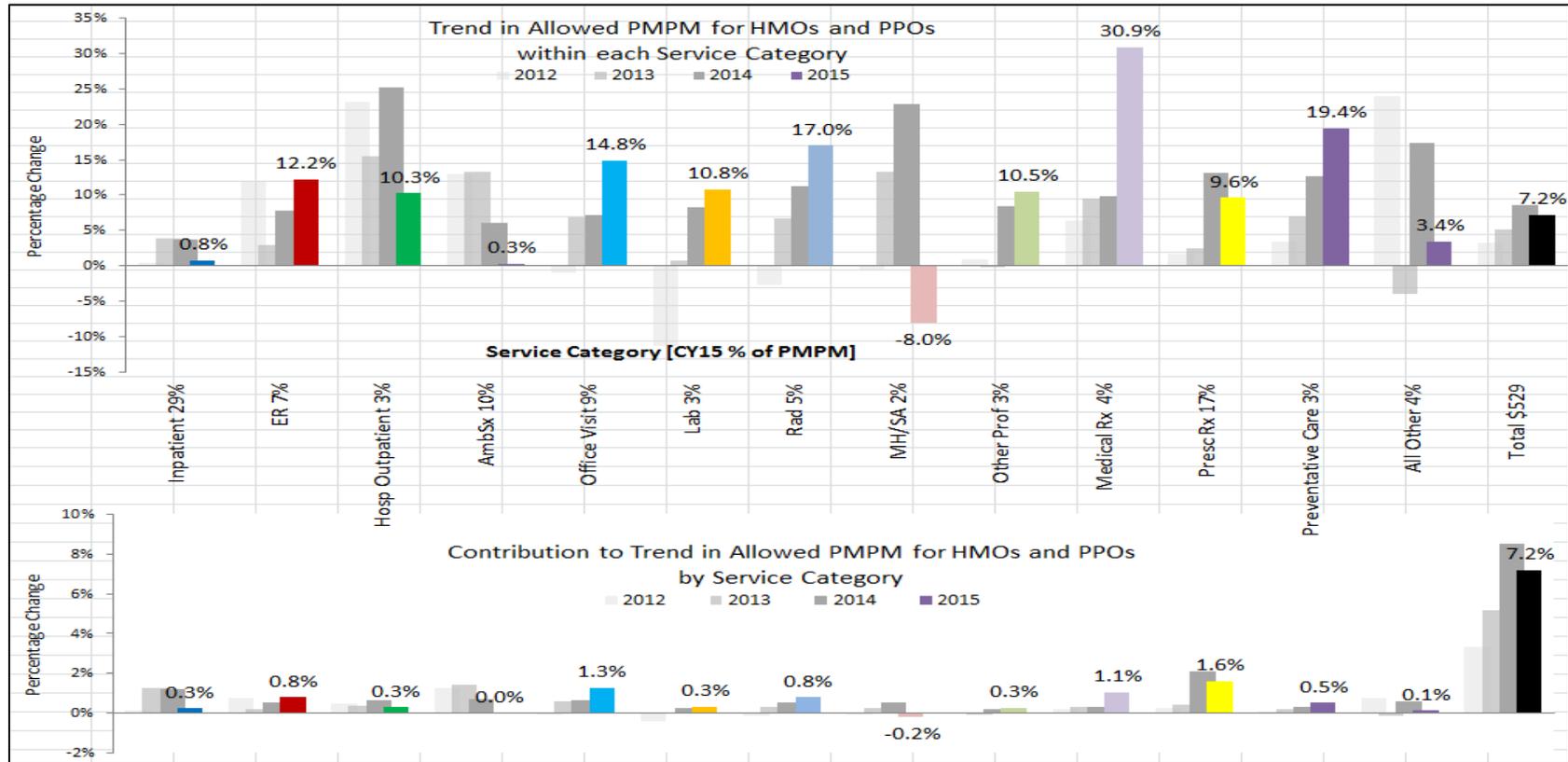
Table 5: 2014 and 2015 Regional Contracting Agency Premiums Medicare (HMO, PPO, and ASN)

Medicare		2014			2015			Percent Change from 2014
		Single	2 Party	Family	Single	2 Party	Family	
HMO	Anthem Blue Cross	\$341.12	\$682.24	\$1,023.36	\$445.38	\$890.76	\$1,336.14	30.56%
	Blue Shield	298.21	596.42	894.63	352.63	705.26	1,057.89	18.25%
	Health Net	261.24	522.48	783.72	276.85	553.70	830.55	5.98%
	Kaiser California	294.97	589.94	884.91	295.51	591.02	886.53	0.18%
	Kaiser Out-of-State	388.65	777.30	1,165.95	390.47	780.94	1,171.41	0.47%
	Sharp	306.51	613.02	919.53	327.66	655.32	982.98	6.90%
	UnitedHealthcare	193.33	386.66	579.99	267.41	534.82	802.23	38.32%
PPO	PERS Choice	307.23	614.46	921.69	339.47	678.94	1,018.41	10.49%
	PERS Select	307.23	614.46	921.69	339.47	678.94	1,018.41	10.49%
	PERSCare	327.36	654.72	982.08	368.76	737.52	1,106.28	12.65%
ASN	PORAC	397.00	791.00	1,264.00	402.00	802.00	1,281.00	1.34%

Appendix E – Medical Trend Changes

Service Category PMPM Change, Trend Drivers

Allowed costs^[1] PMPM^[2] trend is examined across 13 service categories, revealing the key drivers of change between years. Total allowed PMPM increased 7.2 percent across all 13 service categories in calendar year 2015 (CY15). For individual categories, percent changes between years ranged from -8.0 percent to 30.9 percent. Of the major drivers, inpatient increased 0.8 percent, prescription drugs (Presc Rx) increased 9.6 percent, and ambulatory surgery (AmbSx) increased 0.3 percent for calendar year 2015. For calendar year 2015, inpatient, PrescRx, and AmbSx are the major drivers accounting for approximately 56 percent of the total allowed PMPM.



^[1] Contractual “allowed amounts” due to providers inclusive of member out-of-pocket obligations such as coinsurance, co-pays, deductibles, etc. Report shows “allowed” rather than “net” to provide easier comparisons between plans with different benefit designs (e.g., HMO Plans vs PPO Plans)

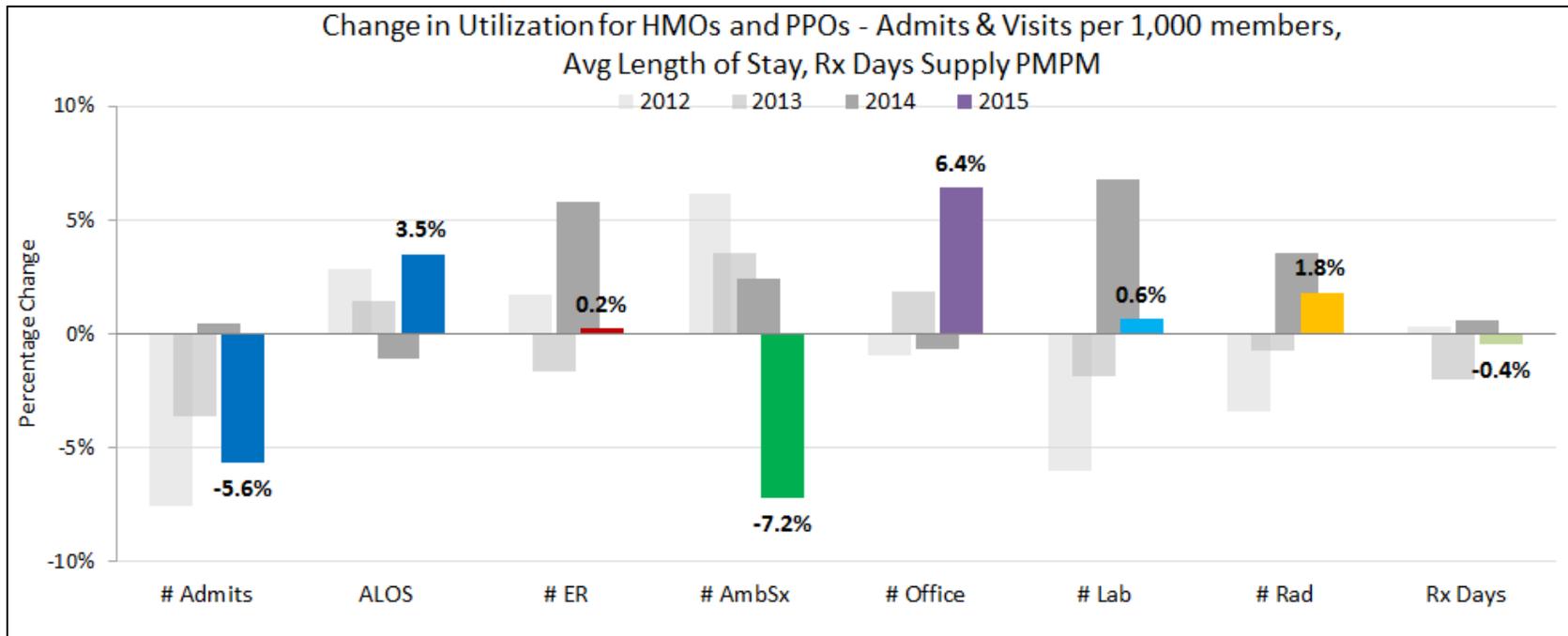
^[2] Allowed cost divided by sum of member months in period, adjusts for population size.

Appendix E – Medical Trend Changes – Continued

Change in Utilization and Unit Price by Key Service Categories

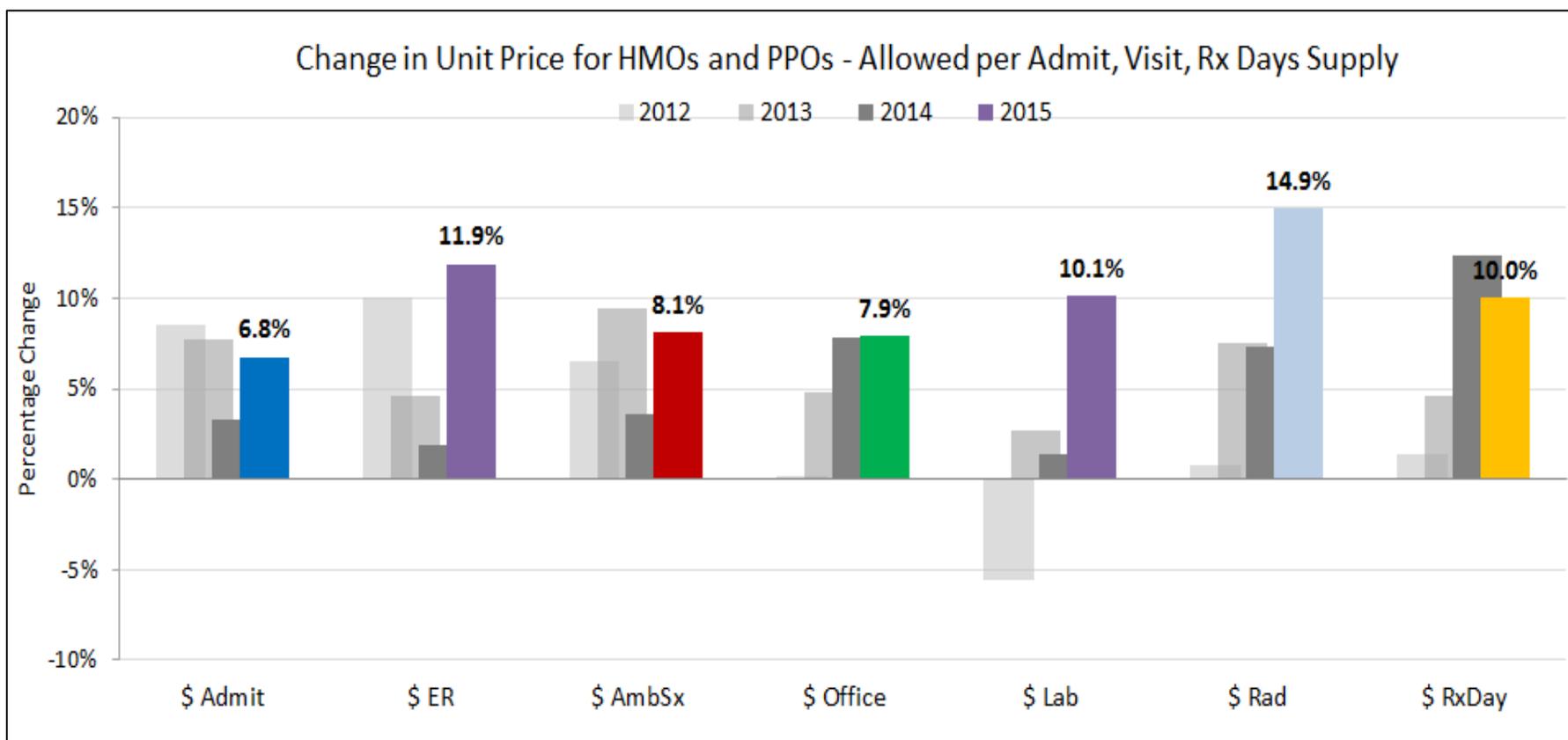
Among the largest service categories, allowed PMPM is driven by change in utilization and price per unit.

- Increases in utilization occurred in average length of stay (ALOS) by 3.5 percent, number of emergency room visits (# ER) by 0.2 percent, number of office visits (# Office) by 6.4 percent, number of laboratory services (# Lab) by 0.6 percent, and number of radiology services (# Rad) by 1.8 percent.
- Decreases in utilization occurred in number of admits (# Admits) by 5.6 percent, number of ambulatory surgery (# AmbSx) by 7.2 percent, and number of prescription drugs days (Rx Days) by 0.4 percent.
- Change in unit price increased across all service categories for calendar year 2015, with radiology experiencing the largest increase of 14.9 percent.



Appendix E – Medical Trend Changes – Continued

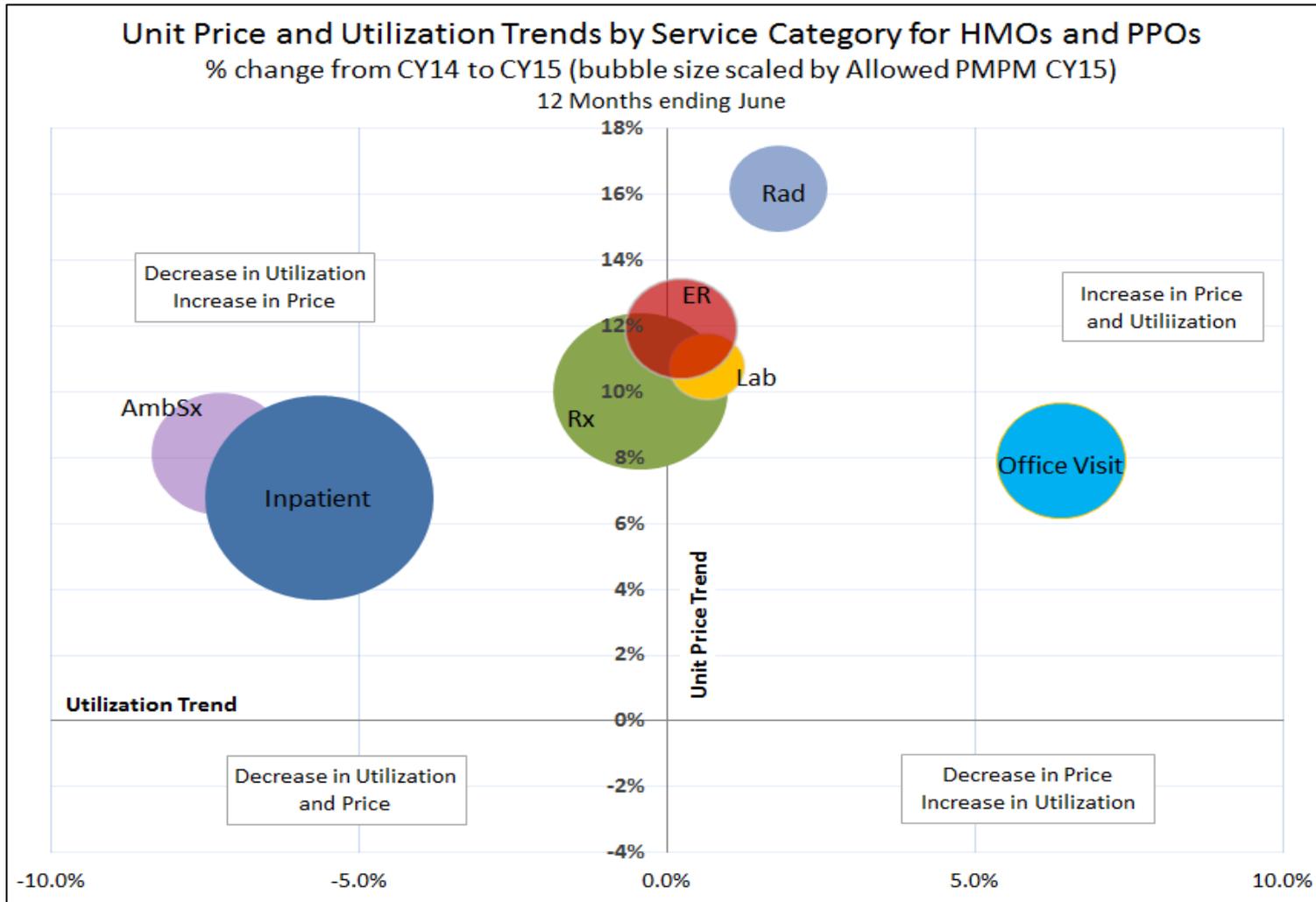
Change in Utilization and Unit Price by Key Service Categories – Continued



Appendix E – Medical Trend Changes – Continued

Utilization and Unit Price Trends by Key Service Category

This chart illustrates the relationship between changes in utilization and price by key service categories where a single metric can be appropriately used for that category. The size of the bubble is the average cost PMPM for the category.



Appendix F – HEDIS

HEDIS AND HEDIS-Like Rates Measurement of 2015 for Reporting Year 2016

Code	Measure	HMO				
		Anthem	BSC	KP North	KP South	UHC
Immunizations for Children and Adolescents						
CIS	Combo 3 (DTaP, IPV, MMR, HiB, HepB, VZV, PVC)*	28.8%	68.5%	88.6%	88.2%	73.1%
CIS	Combo 10 (DTaP, IPV, MMR, HiB, HepB, VZV, PVC, Hep A, RV, Influa)*	16.8%	44.4%	61.9%	59.7%	47.7%
IMA	Meningococcal*	51.2%	73.9%	89.1%	89.1%	64.0%
IMA	Tdap/Td*	62.2%	86.4%	93.5%	92.9%	72.1%
IMA	Combo 1 *	47.2%	72.3%	89.8%		58.6%
Other Prevention and Screening						
ABA	Adult BMI Assessment*	15.3%	80.5%	95.0%	97.1%	85.0%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado BMI Total*	4.1%	56.4%	97.0%	99.1%	56.5%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado Nutrition*	2.5%	47.1%	95.7%	98.9%	56.4%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado Activity Total*	1.5%	40.5%	100.0%	99.3%	56.7%
BCS	Breast Cancer	77.8%	75.2%	88.5%		76.0%
CCS	Cervical Cancer Screening	75.6%	76.1%	91.1%		76.4%
COL	Colorectal Cancer Screening	46.1%	67.7%	82.5%		64.2%
CHL	Chlamydia Screening 16-20	52.1%	43.0%	63.4%	63.5%	50.3%
CHL	Chlamydia Screening 21-24	63.4%	53.3%	71.0%	78.6%	57.1%
CHL	Chlamydia Screening Total	58.3%	48.7%	67.8%	72.6%	54.1%
Respiratory Conditions						
CWP	Appropriate Treatment for Children with Pharyngitis	100.0%	64.2%	94.2%	93.6%	63.0%
URI	Appropriate Treatment for Children with URI	100.0%	89.6%	98.1%	98.5%	92.3%
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	98.8%	25.3%	44.3%	62.9%	27.0%
SPR	Use of Spirometry Testing in COPD	38.5%	32.0%	58.6%	72.9%	25.9%
PCE	Pharmacotherapy Mgt: COPD Exacerbation-systemic corticosteroid		62.1%	84.0%	83.3%	63.9%
PCE	Pharmacotherapy Mgt: COPD Exacerbation-bronchodilator		75.9%	91.4%	93.6%	75.6%
Cardiac Conditions						
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack		83.1%	88.1%		78.2%
Comprehensive Diabetes Care						
CDC	Hemoglobin A1c (HbA1c) Testing*	89.0%	88.9%	95.6%		90.3%
CDC	HbA1c Poor Control (>9.0%)	36.5%	25.8%	80.0%		25.6%
CDC	HbA1c Control (<8.0%)*	54.7%	64.9%	67.5%		62.6%
CDC	Eye Exam (retinal) performed*	29.7%	48.7%	71.9%		47.6%
CDC	Medical Attention for Nephropathy*	80.8%	90.7%	94.3%		92.2%
Musculoskeletal						
ART	Drug Therapy in Rheumatoid Arthritis	17.8%	86.9%	91.0%	96.5%	82.9%
LBP	Use of Imaging Studies for Low Back Pain	81.1%	77.2%	89.8%		80.1%
Behavioral Health						
AMM	Antidepressant Med Mgt: Acute Treatment	55.6%	58.4%	75.7%		54.9%
AMM	Antidepressant Med Mgt.-Continuation Treatment	33.3%	43.8%	52.4%		40.2%
ADD	Follow-Up Care for ADHD Therapy - Initiation Phase	100.0%	38.4%	57.2%	48.6%	35.1%
ADD	Follow-Up ADHD Therapy -Cont. & Maintenance Phase		51.3%	56.5%	49.1%	40.8%
FUH	Follow-Up After Hospitalization for Mental Illness: 7 Day	48.3%	68.5%	73.9%	76.8%	61.7%
FUH	Follow-Up After Hospitalization for Mental Illness: 30 Day	79.3%	80.3%	84.7%	84.4%	76.8%
Medication Management						
MPM	Annual monitoring for members on ACEI or ARBS	76.1%	79.4%	87.9%	88.3%	82.9%
MPM	Annual monitoring for members on digoxin		40.7%	51.1%	74.2%	54.6%
MPM	Annual monitoring for members on diuretics	74.1%	78.8%	85.5%	86.7%	82.3%
MPM	Annual monitoring total rate	75.3%	79.0%	86.7%	87.6%	82.5%
Maternity Care						
PPC	Prenatal care*	48.4%	83.2%	96.4%	97.1%	71.7%
PPC	Postpartum care*	35.2%	76.5%	95.6%	90.8%	57.4%
Chronic Care Management						
IET	Initiation: Alcohol/Drug Dependence Treatment	28.4%	26.6%	54.6%	39.1%	27.5%
IET	Engagement; Alcohol/Drug Dependence Treatment	11.0%	5.8%	26.3%	17.3%	9.6%

* "Hybrid measure" for which HMOs gather additional information from patients' medical records.

The Code column includes three-letter designations used by the NCQA to uniquely identify HEDIS measures. Blank cells indicate that data were unavailable.

Plan Abbreviations and Acronyms:

BSB = Blue Shield of CA KP = Kaiser Permanente UHC = United Health Care

Abbreviations and Acronyms used in Measures:

ACEI = Angiotensin-converting enzyme inhibitor	MMR = Measles, mumps, rubella	IPV = Inactivated poliovirus
ADHD = Attention Deficit Hyperactivity Disorder	PVC = Pneumococcal Conjugate Vaccine	
ARBS = Angiotensin receptor blockers	RV = Rotavirus	
BMI = Body Mass Index	URI = Upper Respiratory Infection	
COPD = Chronic Obstructive Pulmonary Disease	VZV = Varicella (Chickenpox)	
DTap = Diphtheria, Tetanus and Pertussis	Tdap/Td = Tetanus, Diphtheria, Pertussis / Tetanus and Diphtheria	
Hep A = Hepatitis	HiB = Haemophilus Influenzae type B	
HepB = Hepatitis B	Influ = Influenza	

Appendix F – HEDIS – Continued

HEDIS AND HEDIS-Like Rates Measurement of 2015 for Reporting Year 2016

Code	Measure	PPO		
		Care	Choice	Select
Immunizations for Children and Adolescents				
CIS	Combo 3 (DTaP, IPV, MMR, HiB, HepB, VZV, PVC)*	24.2%	41.9%	40.9%
CIS	Combo 10 (DTaP, IPV, MMR, HiB, HepB, VZV, PVC, Hep A, RV, Inlu)*	17.6%	25.8%	18.8%
IMA	Meningococcal*	64.2%	58.2%	45.0%
IMA	Tdap/Td*	72.4%	79.6%	77.3%
IMA	Combo 1 *	58.2%	55.8%	42.4%
Other Prevention and Screening				
ABA	Adult BMI Assessment*	9.6%	7.3%	7.0%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado BMI Total*	4.4%	3.5%	3.5%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado Nutrition*	4.3%	3.7%	3.6%
WCC	Wgt Assessment & Counseling for Nutrition/Physical Activity Child/Ado Activity Total*	2.3%	1.9%	2.0%
BCS	Breast Cancer	74.1%	70.7%	65.8%
CCS	Cervical Cancer Screening	73.0%	70.8%	70.7%
COL	Colorectal Cancer Screening	63.1%	61.8%	50.9%
CHL	Chlamydia Screening 16-20	34.7%	33.7%	29.3%
CHL	Chlamydia Screening 21-24	41.7%	47.3%	45.2%
CHL	Chlamydia Screening Total	38.8%	41.6%	37.9%
Respiratory Conditions				
CWP	Appropriate Treatment for Children with Pharyngitis	76.1%	65.5%	62.5%
URI	Appropriate Treatment for Children with URI	92.5%	89.2%	88.6%
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	17.9%	22.1%	19.3%
SPR	Use of Spirometry Testing in COPD	43.1%	31.9%	28.2%
PCE	Pharmacotherapy Mgt: COPD Exacerbation-systemic corticosteroid	66.7%	74.8%	22.2%
PCE	Pharmacotherapy Mgt: COPD Exacerbation-bronchodilator	71.4%	86.9%	66.7%
Cardiac Conditions				
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	88.9%	86.2%	66.7%
Comprehensive Diabetes Care				
CDC	Hemoglobin A1c (HbA1c) Testing*	87.9%	86.2%	84.3%
CDC	HbA1c Poor Control (>9.0%)	66.1%	69.7%	66.6%
CDC	HbA1c Control (<8.0%)*	29.8%	26.8%	28.3%
CDC	Eye Exam (retinal) performed*	38.6%	32.4%	29.9%
CDC	Medical Attention for Nephropathy*	90.1%	87.7%	84.2%
Musculoskeletal				
ART	Drug Therapy in Rheumatoid Arthritis	85.2%	85.8%	78.8%
LBP	Use of Imaging Studies for Low Back Pain	84.1%	81.7%	82.2%
Behavioral Health				
AMM	Antidepressant Med Mgt: Acute Treatment	72.6%	72.0%	67.7%
AMM	Antidepressant Med Mgt.-Continuation Treatment	61.3%	58.2%	52.9%
ADD	Follow-Up Care for ADHD Therapy - Initiation Phase	46.7%	35.4%	46.3%
ADD	Follow-Up ADHD Therapy -Cont. & Maintenance Phase	50.0%	46.5%	48.1%
FUH	Follow-Up After Hospitalization for Mental Illness: 7 Day	54.2%	54.0%	37.5%
FUH	Follow-Up After Hospitalization for Mental Illness: 30 Day	73.6%	71.7%	65.6%
Medication Management				
MPM	Annual monitoring for members on ACEI or ARBS	83.4%	80.9%	74.9%
MPM	Annual monitoring for members on digoxin	46.8%	44.2%	23.5%
MPM	Annual monitoring for members on diuretics	84.1%	80.7%	74.1%
MPM	Annual monitoring total rate	83.3%	80.6%	74.4%
Maternity Care				
PPC	Prenatal care*	63.3%	61.9%	61.4%
PPC	Postpartum care*	32.1%	31.1%	36.3%
Chronic Care Management				
IET	Initiation: Alcohol/Drug Dependence Treatment	33.3%	28.2%	31.7%
IET	Engagement; Alcohol/Drug Dependence Treatment	12.3%	8.6%	10.6%

*"Hybrid measure" for which HMOs gather additional information from patients' medical records.

The Code column includes three-letter designations used by the NCQA to uniquely identify HEDIS measures. Blank cells indicate that data were unavailable.

Plan Abbreviations and Acronyms:

Care = PERSCare Choice = PERS Choice Select = PERS Select

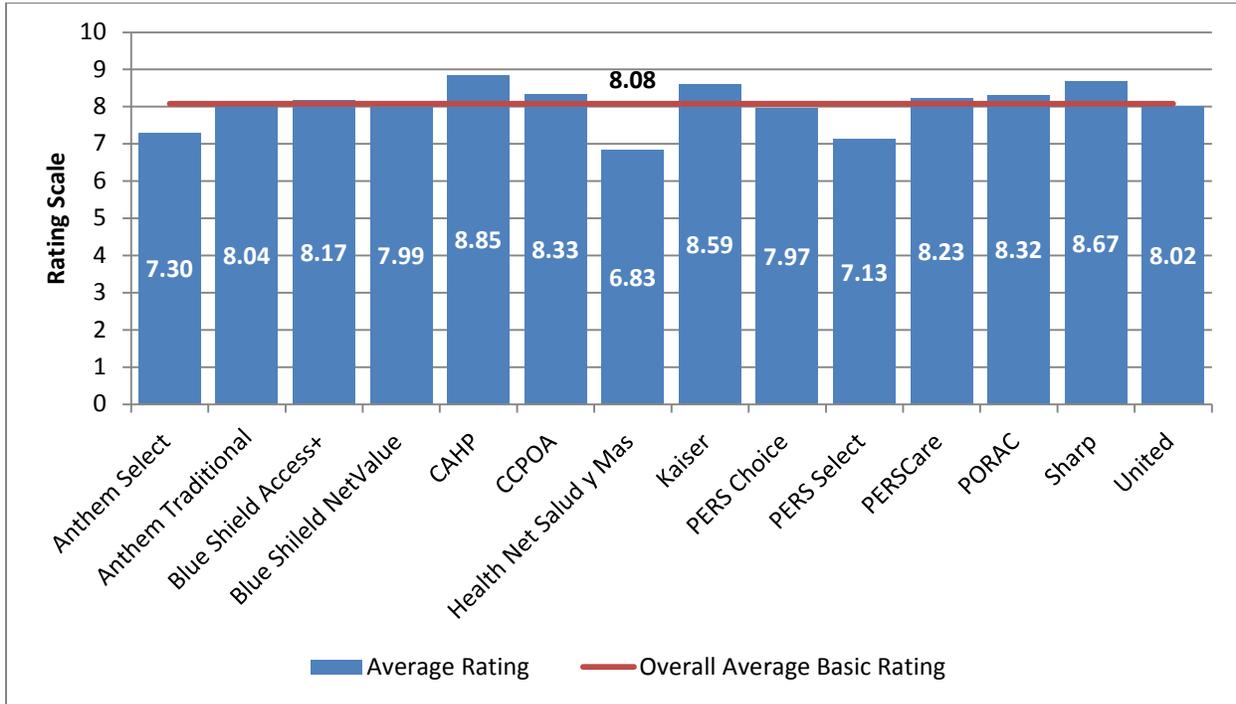
Abbreviations and Acronyms used in Measures:

ACEI = Angiotensin-converting enzyme inhibitor
 ADHD = Attention Deficit Hyperactivity Disorder
 ARBS = Angiotensin receptor blockers
 BMI = Body Mass Index
 COPD = Chronic Obstructive Pulmonary Disease
 DTaP = Diphtheria, Tetanus and Pertussis
 Hep A = Hepatitis
 HepB = Hepatitis B
 MMR = Measles, mumps, rubella
 IPV = Inactivated poliovirus
 PVC = Pneumococcal Conjugate Vaccine
 RV = Rotavirus
 URI = Upper Respiratory Infection
 VZV = Varicella (Chickenpox)
 Tdap/Td = Tetanus, Diphtheria, Pertussis / Tetanus and Diphtheria
 HiB = Haemophilus Influenzae type B
 Inlu = Influenza

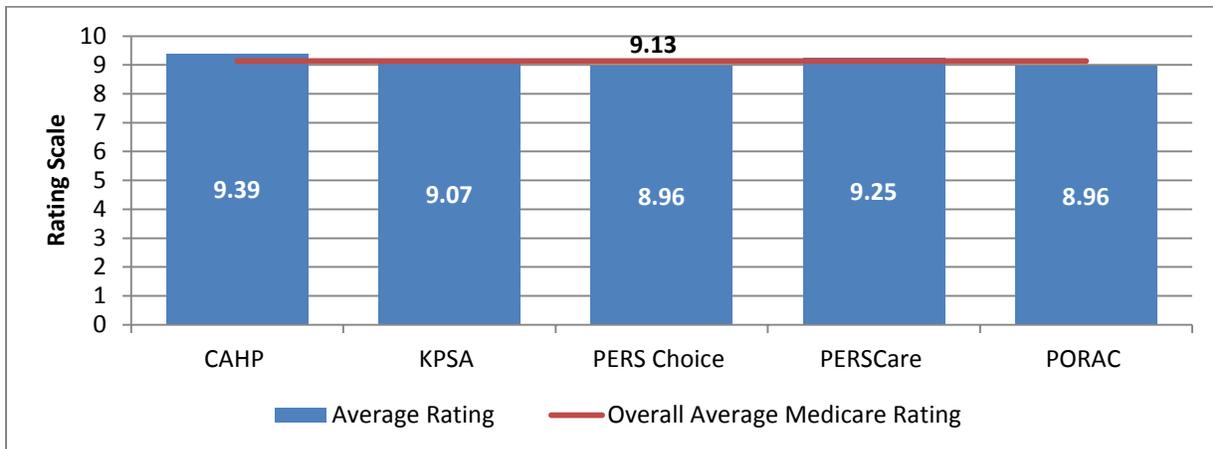
Appendix G – 2015 Health Plan Member Survey Results

Members were asked: Using any number between 0 and 10, where 0 means extremely dissatisfied and 10 means extremely satisfied, what number would you use to rate your health plan?

Individual Basic: Health Plan Satisfaction Ratings



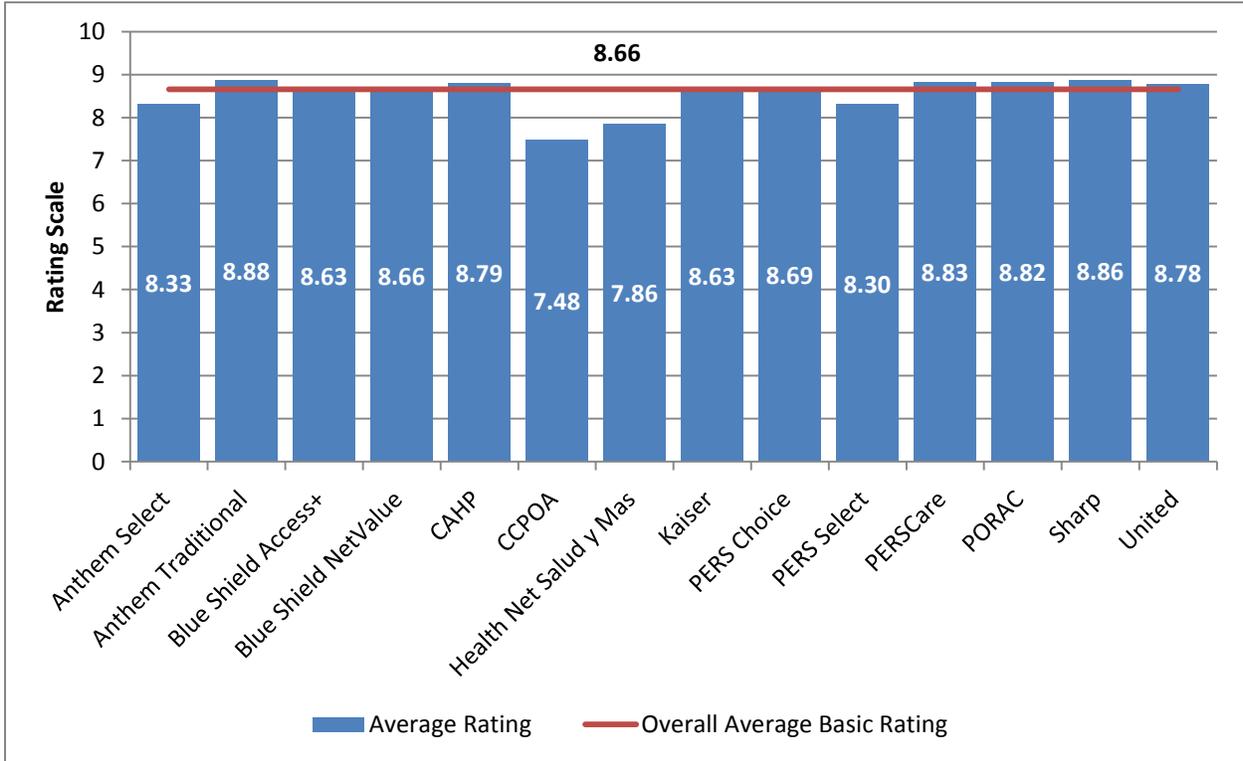
Individual Medicare: Health Plan Satisfaction Ratings



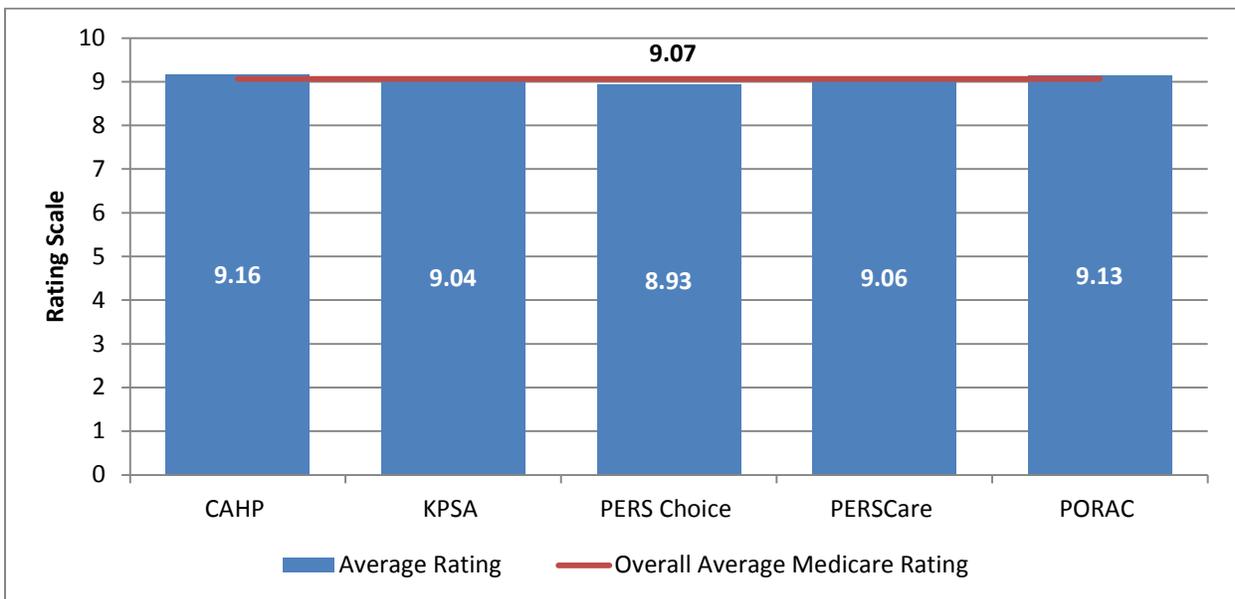
Appendix G – 2015 Health Plan Member Survey Results – Continued

Members were asked: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Individual Basic: Personal Doctor Satisfaction Ratings



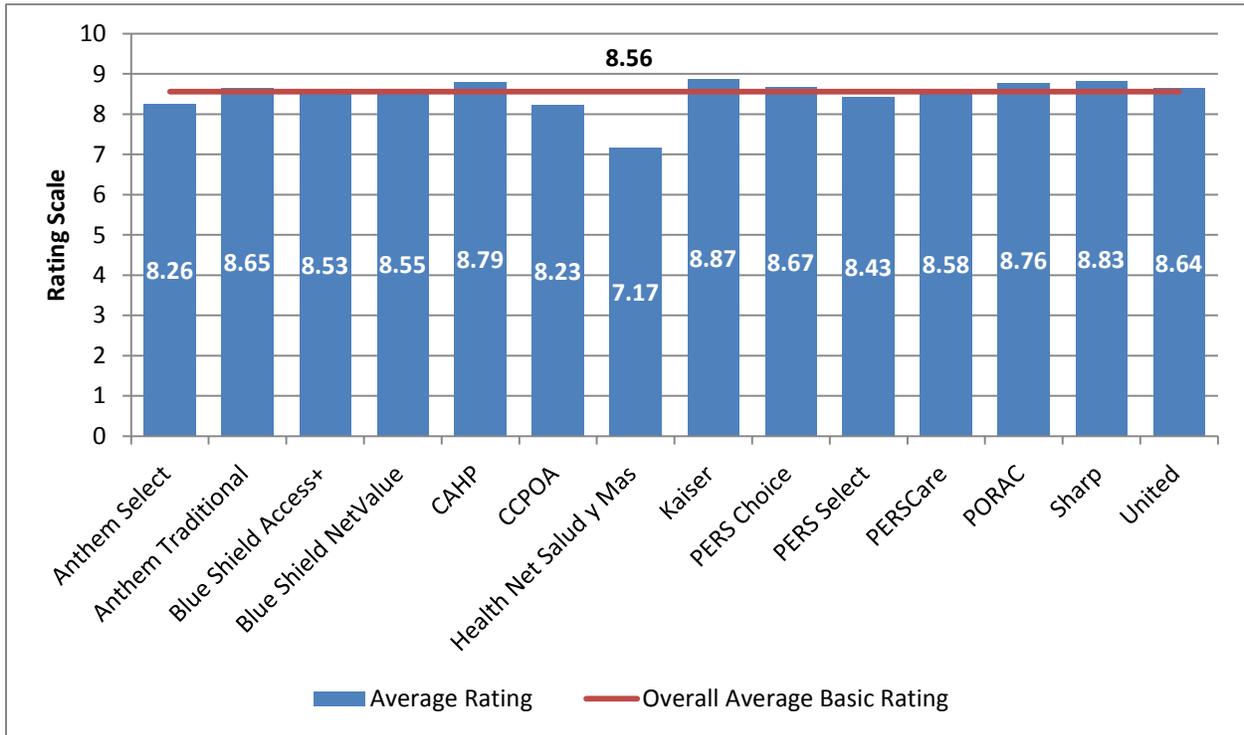
Individual Medicare: Personal Doctor Satisfaction Ratings



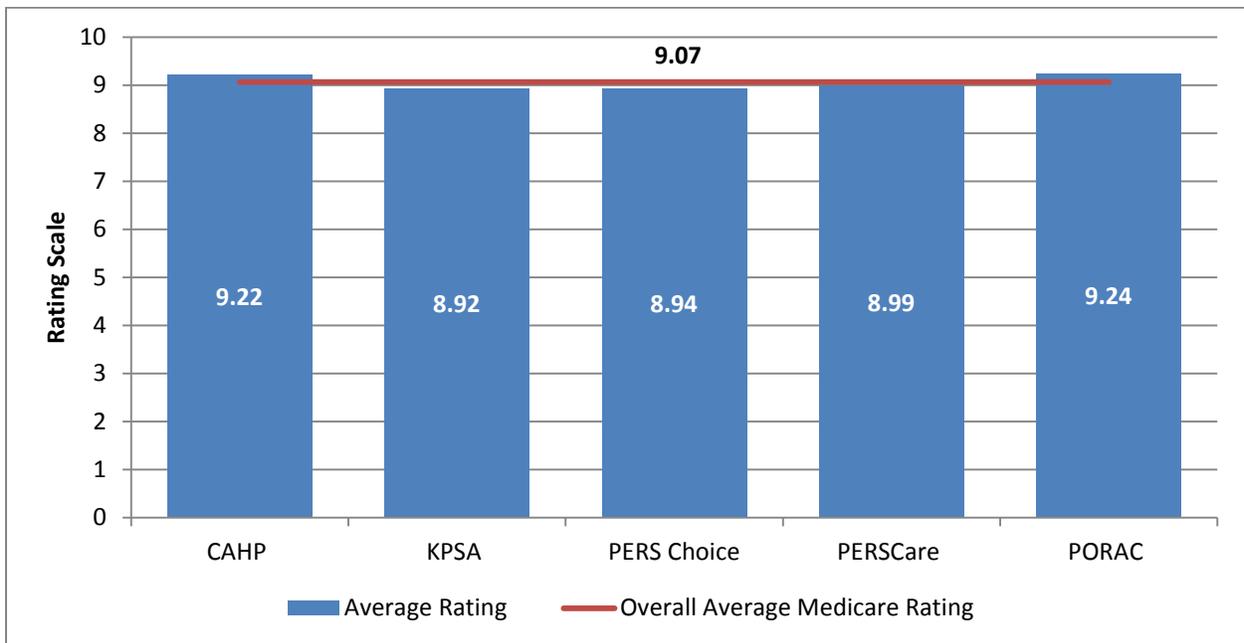
Appendix G – 2015 Health Plan Member Survey Results – Continued

Members were asked: We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

Individual Basic: Specialist Satisfaction Ratings



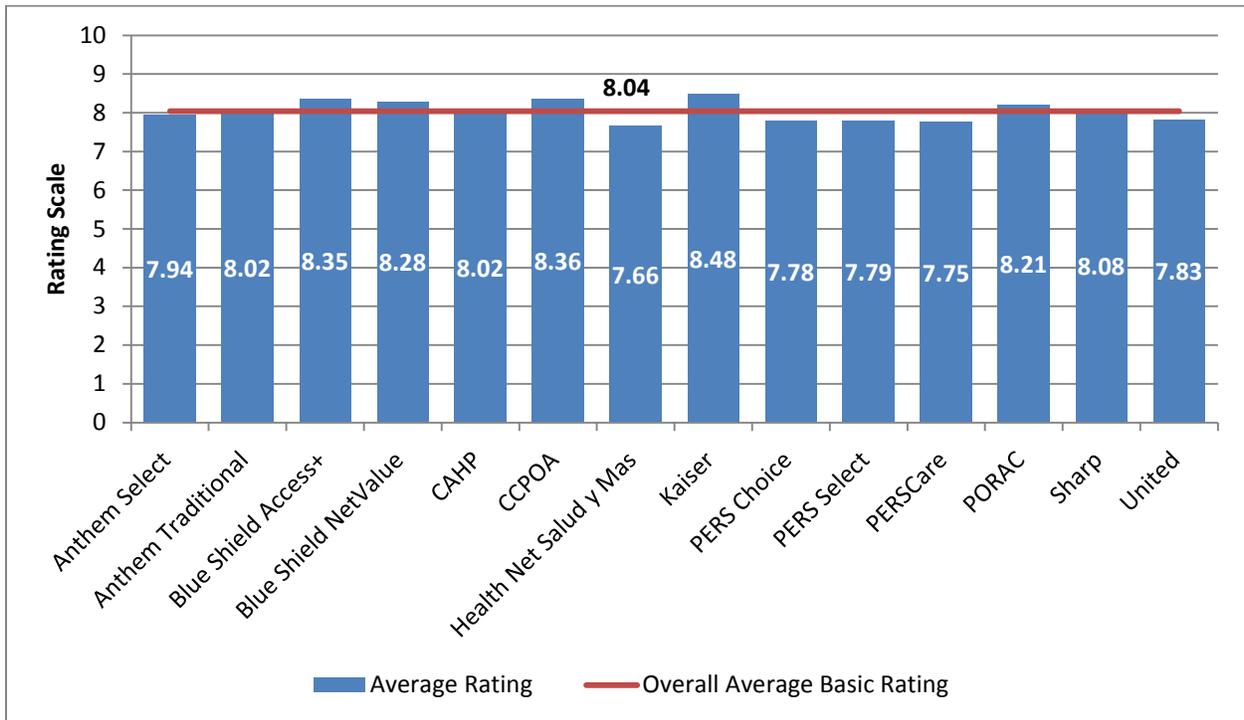
Individual Medicare Specialist Satisfaction Ratings



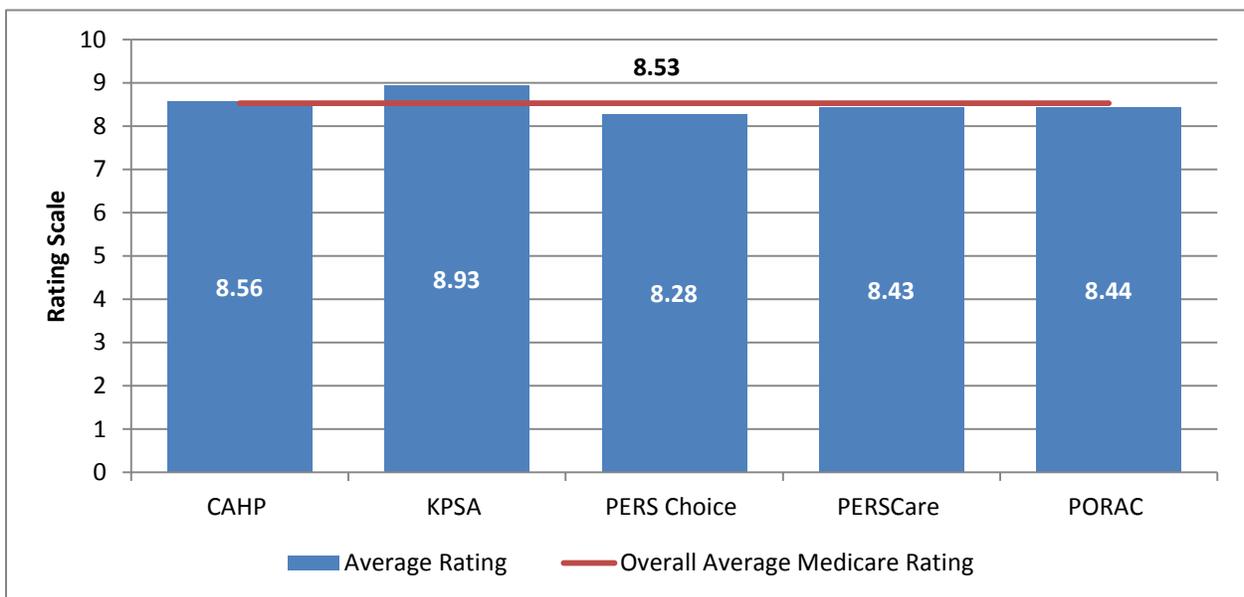
Appendix G – 2015 Health Plan Member Survey Results – Continued

Members were asked: Using any number from 0 to 10, where 0 is the worst pharmacy services possible and 10 is the best pharmacy services possible, what number would you use to rate your overall satisfaction with your pharmacy services (i.e., your experience with obtaining prescriptions from a retail or mail order pharmacy)?

Individual Basic Pharmacy Services Satisfaction Ratings



Individual Medicare: Personal Pharmacy Services Satisfaction Ratings



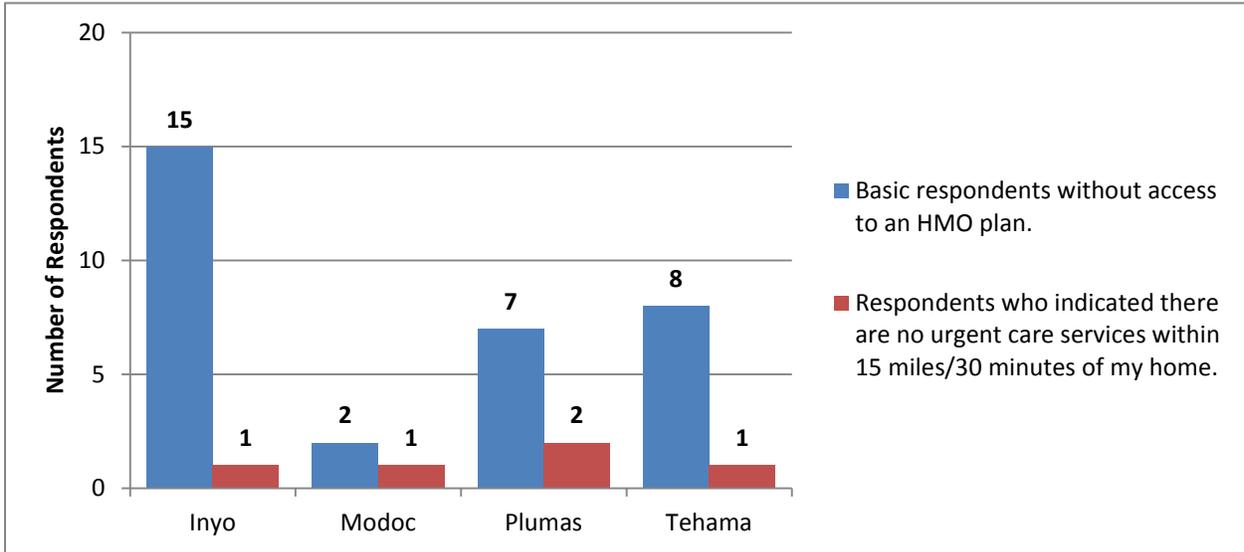
Appendix G – 2015 Health Plan Member Survey Results – Continued

Urgent Care: Basic

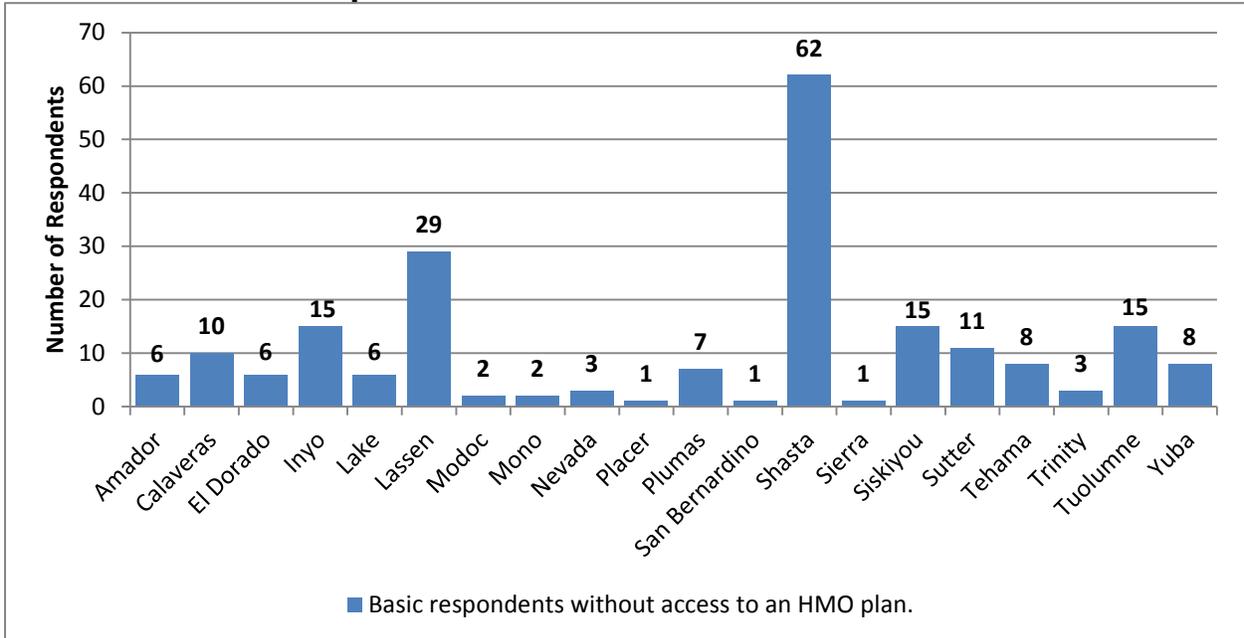
Members were asked: In the last 12 months, if you went to an emergency room to get care for yourself, why did you go?

Members who responded: There are no urgent care services within 15 miles/30 minutes of my home.

Basic Rural Urgent Care Accessibility



Basic Rural PPO Respondents Without Access to an HMO Plan



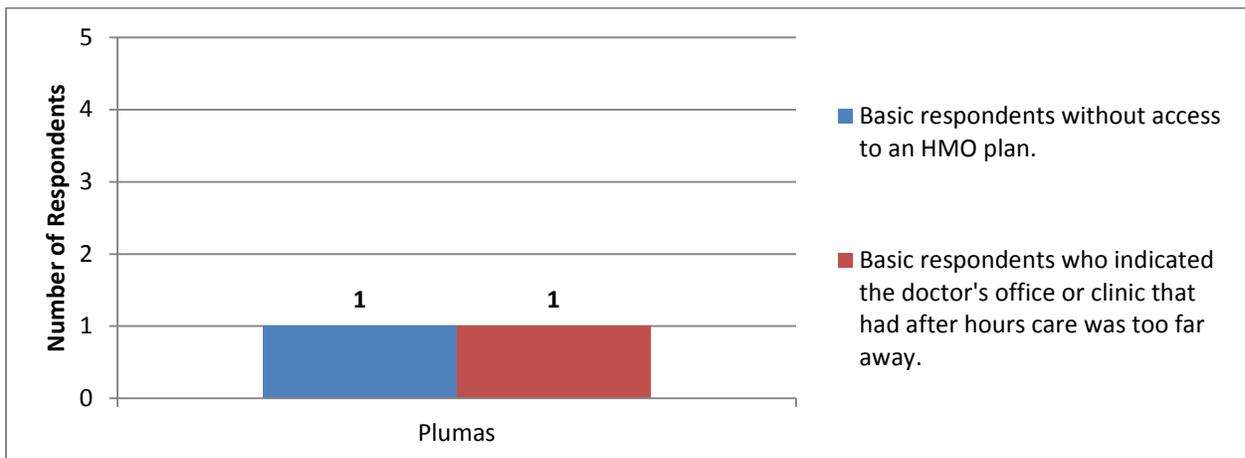
Appendix G – 2015 Health Plan Member Survey Results – Continued

After Hours Care: Basic

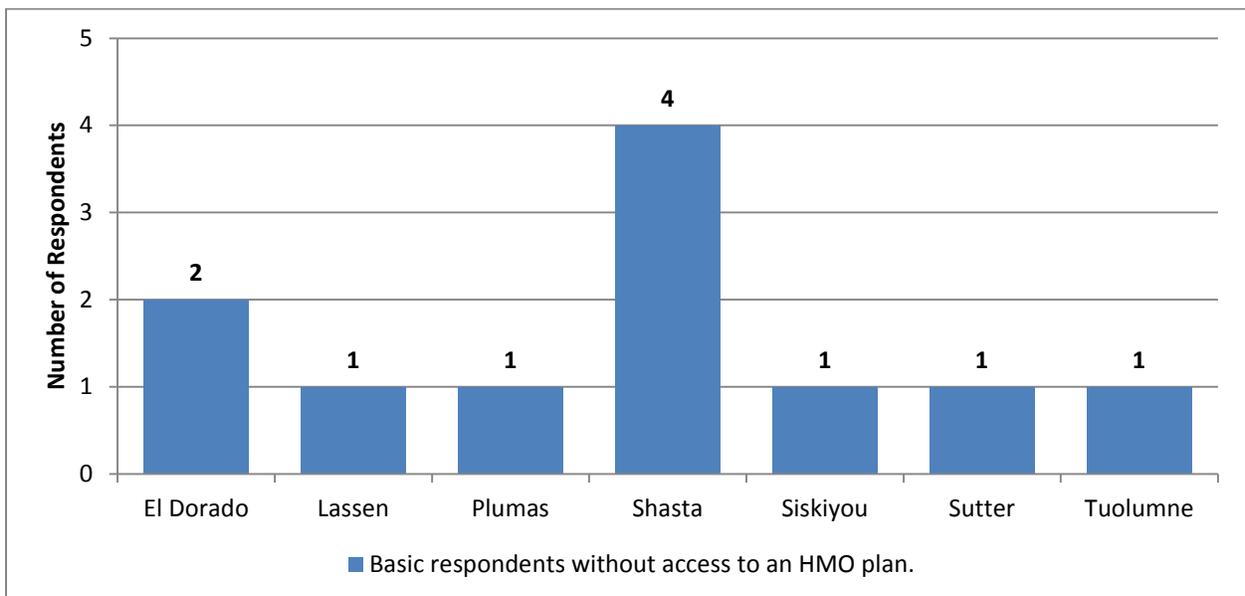
Members were asked: Were any of the following a reason it was not easy to get the after-hours care you thought you needed?

Members who responded: The doctor's office or clinic that had after-hours care was too far away.

Basic Rural After Hours Care Accessibility



Basic PPO Respondents Without Access to an HMO Plan



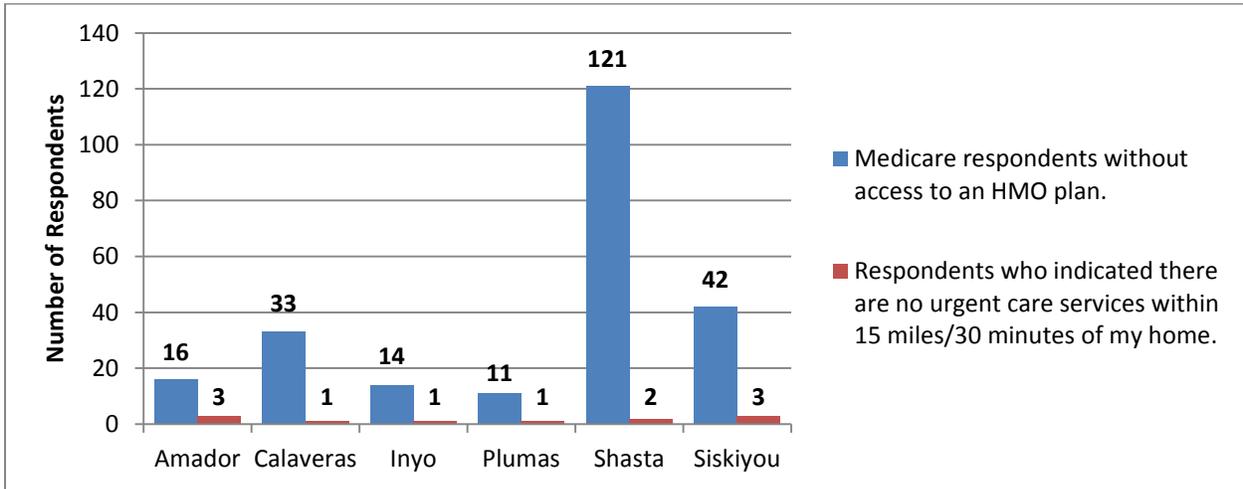
Appendix G – 2015 Health Plan Member Survey Results – Continued

Urgent Care: Medicare

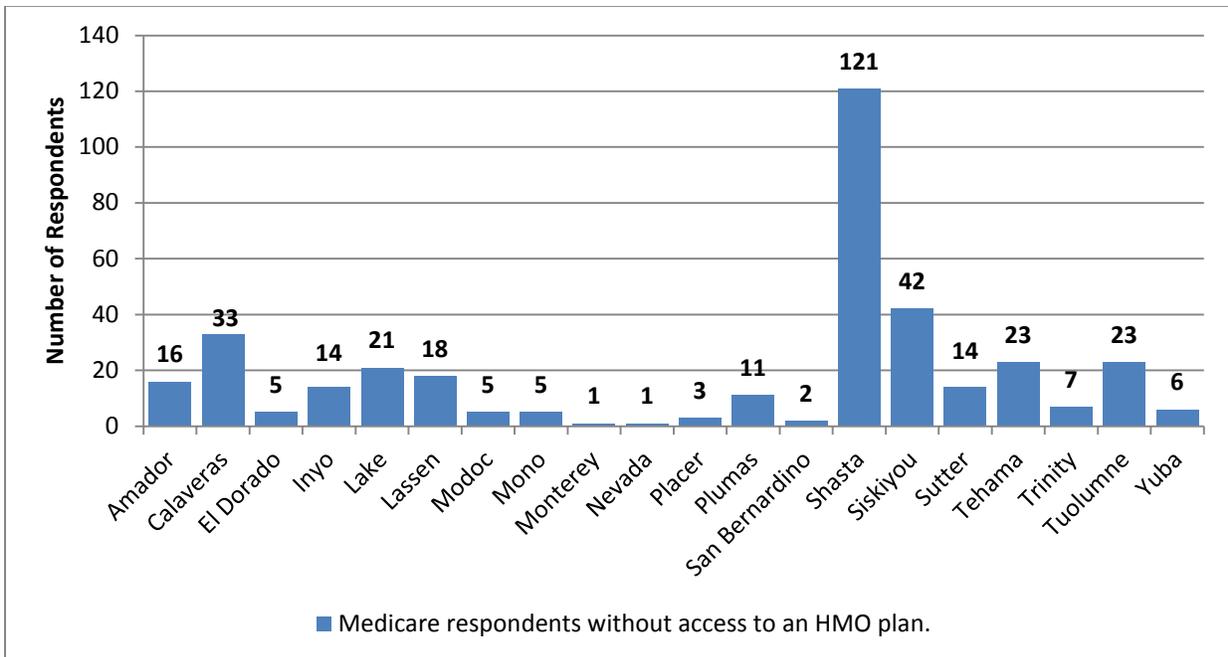
Members were asked: In the last 12 months, if you went to an emergency room to get care for yourself, why did you go?

Members who responded: There are no urgent care services within 15 miles/30 minutes of my home.

Medicare Rural Urgent Care Accessibility



Medicare Rural PPO Respondents Without Access to an HMO Plan



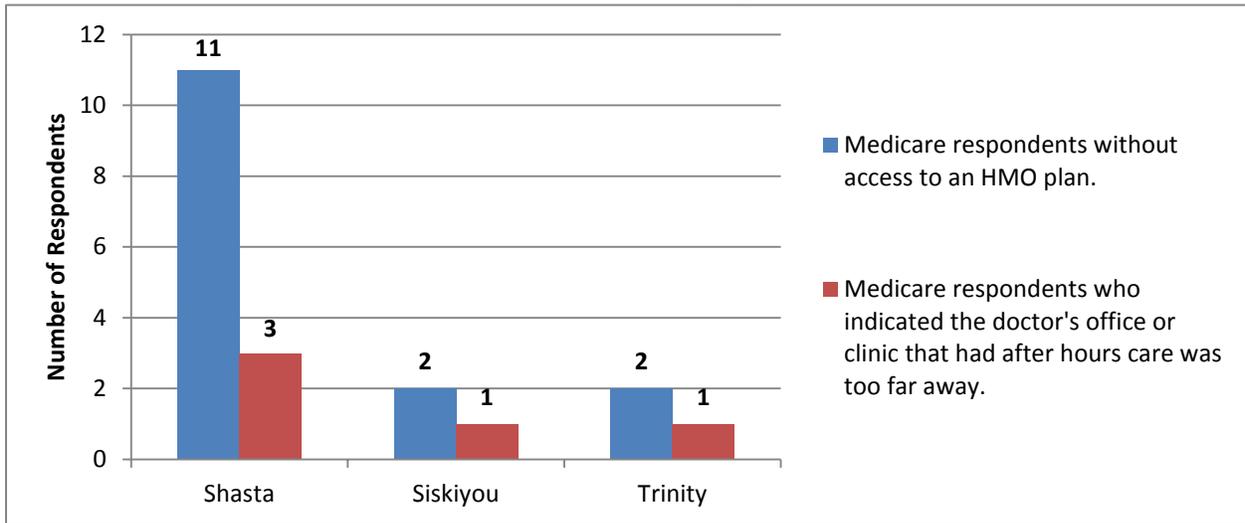
Appendix G – 2015 Health Plan Member Survey Results – Continued

After Hours Care: Medicare

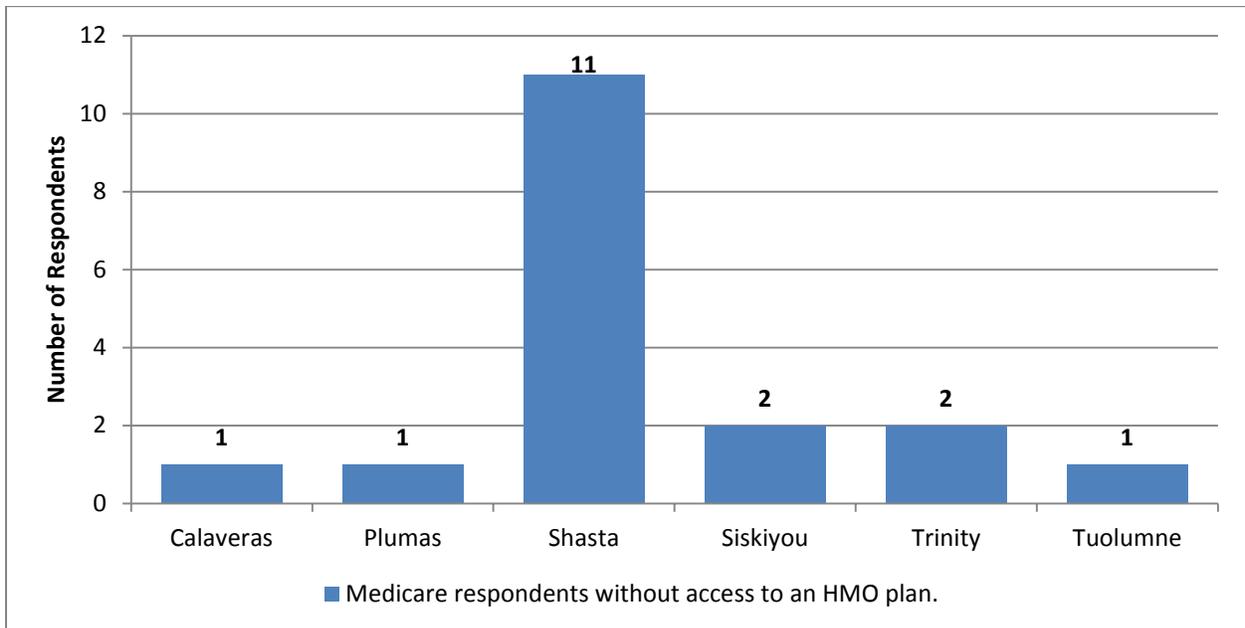
Members were asked: Were any of the following a reason it was not easy to get the after-hours care you thought you needed?

Members who responded: The doctor’s office or clinic that had after hours care was too far away.

Medicare Rural After Hours Care Accessibility



Medicare PPO Respondents Without Access to an HMO Plan



Appendix H – Surplus Money Investment Fund (SMIF)

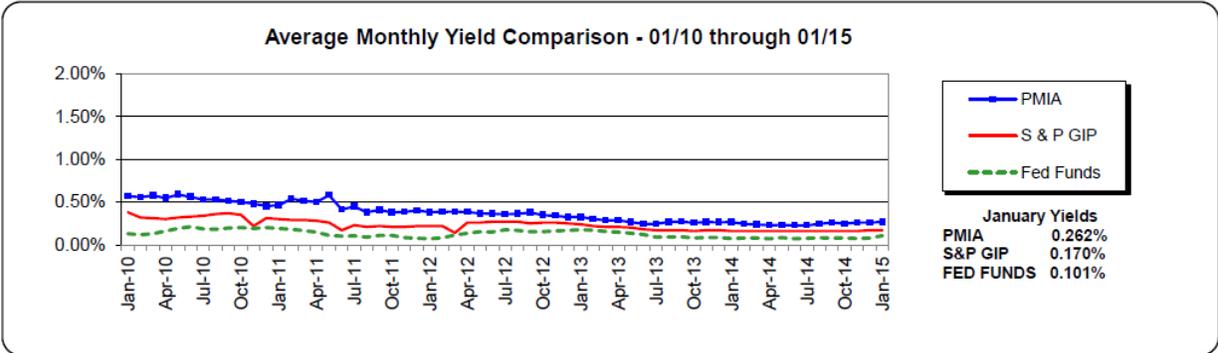
STATE CONTROLLER'S OFFICE Division of Accounting and Reporting Surplus Money Investment Fund (SMIF) Apportionment Yield Rate

Period Ending	Rate	Period Ending	Rate	Period Ending	Rate	Period Ending	Rate
12/31/1964	3.777%	6/30/1981	11.488%	12/31/1997	5.690%	3/31/2009	1.903%
6/30/1965	3.968%	12/31/1981	12.188%	6/30/1998	5.674%	6/30/2009	1.512%
12/31/1965	4.184%	6/30/1982	11.931%	12/31/1998	5.553%	9/30/2009	0.889%
6/30/1966	4.538%	12/31/1982	11.262%	6/30/1999	5.134%	12/31/2009	0.594%
12/31/1966	5.057%	6/30/1983	9.849%	12/31/1999	5.341%	3/31/2010	0.551%
6/30/1967	4.815%	12/31/1983	10.120%	6/30/2000	5.986%	6/30/2010	0.559%
12/31/1967	4.744%	6/30/1984	10.605%	12/31/2000	6.493%	9/30/2010	0.503%
6/30/1968	5.333%	12/31/1984	11.475%	6/30/2001	5.731%	12/31/2010	0.456%
12/31/1968	5.540%	6/30/1985	10.191%	12/31/2001	3.993%	3/31/2011	0.508%
6/30/1969	6.520%	12/31/1985	9.497%	6/30/2002	2.853%	6/30/2011	0.480%
12/31/1969	6.389%	6/30/1986	8.701%	12/31/2002	2.468%	9/30/2011	0.377%
6/30/1970	7.072%	12/31/1986	7.655%	6/30/2003	1.859%	12/31/2011	0.378%
12/31/1970	7.696%	6/30/1987	7.220%	12/31/2003	1.590%	3/31/2012	0.374%
6/30/1971	5.154%	12/31/1987	7.772%	3/31/2004	1.467%	6/30/2012	0.361%
12/31/1971	5.580%	6/30/1988	7.946%	6/30/2004	1.441%	9/30/2012	0.349%
6/30/1972	4.477%	12/31/1988	8.336%	9/30/2004	1.665%	12/31/2012	0.316%
12/31/1972	4.977%	6/30/1989	8.956%	12/31/2004	1.995%	3/31/2013	0.275%
6/30/1973	6.023%	12/31/1989	8.784%	3/31/2005	2.373%	6/30/2013	0.246%
12/31/1973	8.717%	6/30/1990	8.520%	6/30/2005	2.851%	9/30/2013	0.249%
6/30/1974	9.222%	12/31/1990	8.339%	9/30/2005	3.178%	12/31/2013	0.248%
12/31/1974	10.315%	6/30/1991	7.674%	12/31/2005	3.626%	3/31/2014	0.222%
6/30/1975	7.089%	12/31/1991	6.761%	3/31/2006	4.032%	6/30/2014	0.228%
12/31/1975	6.791%	6/30/1992	5.649%	6/30/2006	4.529%	9/30/2014	0.234%
6/30/1976	6.048%	12/31/1992	4.821%	9/30/2006	4.926%	12/31/2014	0.249%
12/31/1976	6.021%	6/30/1993	4.605%	12/31/2006	5.106%	3/31/2015	0.254%
6/30/1977	5.788%	12/31/1993	4.390%	3/31/2007	5.172%	6/30/2015	0.283%
12/31/1977	6.182%	6/30/1994	4.354%	6/30/2007	5.235%	9/30/2015	0.316%
6/30/1978	7.174%	12/31/1994	5.153%	9/30/2007	5.236%	12/31/2015	0.364%
12/31/1978	8.096%	6/30/1995	5.871%	12/31/2007	4.955%	3/31/2016	0.460%
6/30/1979	8.979%	12/31/1995	5.827%	3/31/2008	4.174%	6/30/2016	0.543%
12/31/1979	9.671%	6/30/1996	5.560%	6/30/2008	3.108%		
6/30/1980	11.376%	12/31/1996	5.572%	9/30/2008	2.769%		
12/31/1980	10.257%	6/30/1997	5.594%	12/31/2008	2.533%		

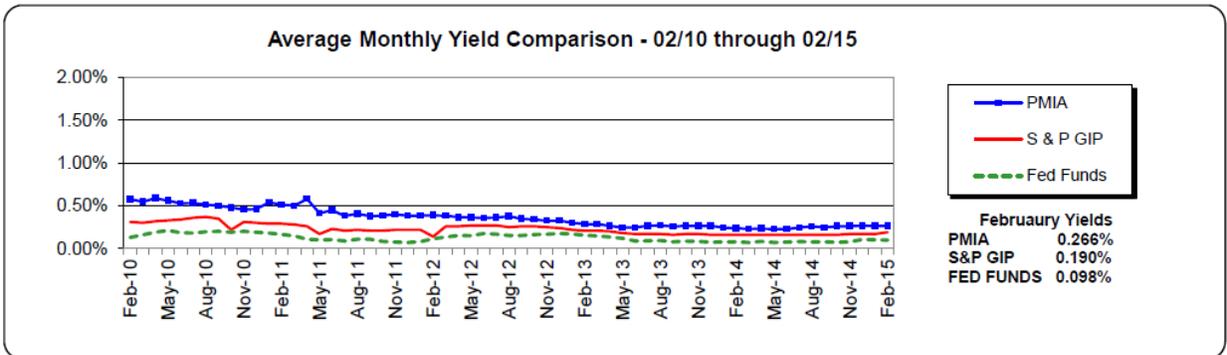
Appendix I – Pooled Money Investment Account (PMIA), Standard and Poor’s Government Investment Pool (S&P GIP), and Federal Funds Average Monthly Yield Comparison

Source: State Treasurer’s Office

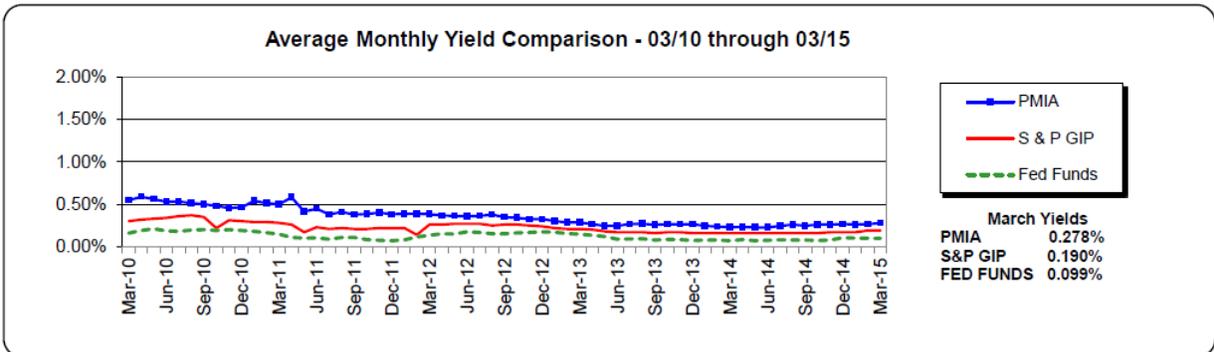
January 2010 – January 2015



February 2010 – February 2015

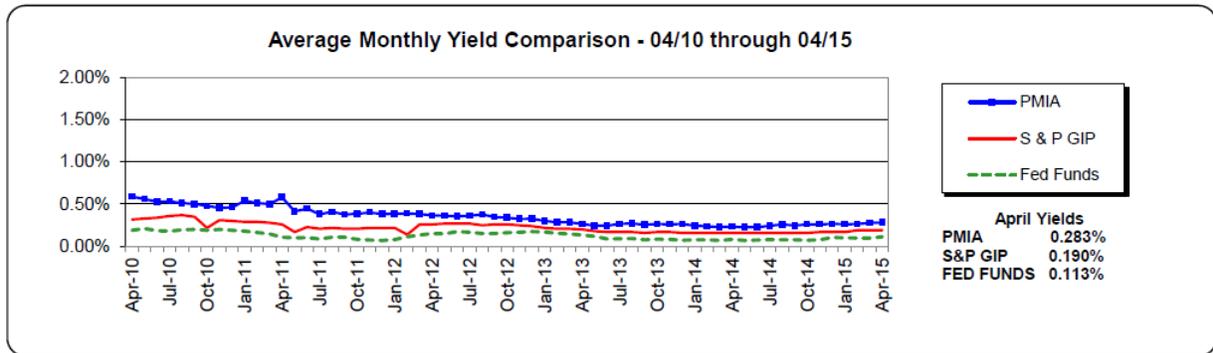


March 2010 – March 2015

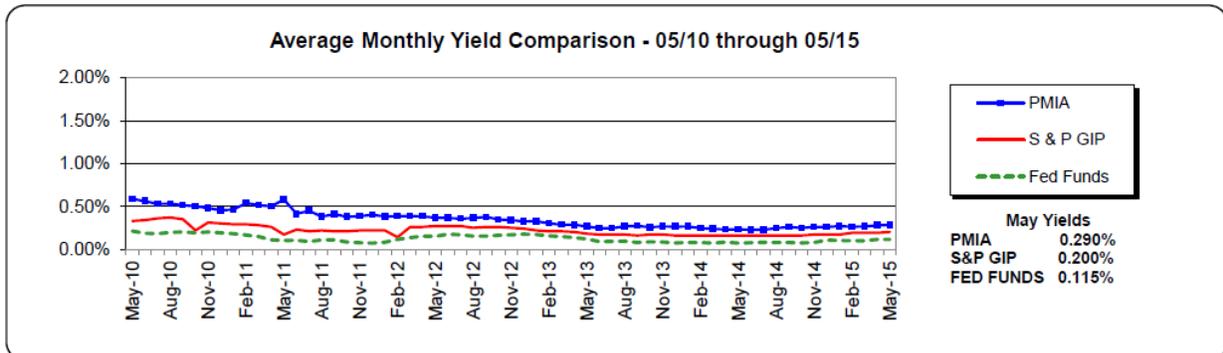


Appendix I – Pooled Money Investment Account (PMIA), Standard and Poor’s Government Investment Pool (S&P GIP), and Federal Funds Average Monthly Yield Comparison – Continued

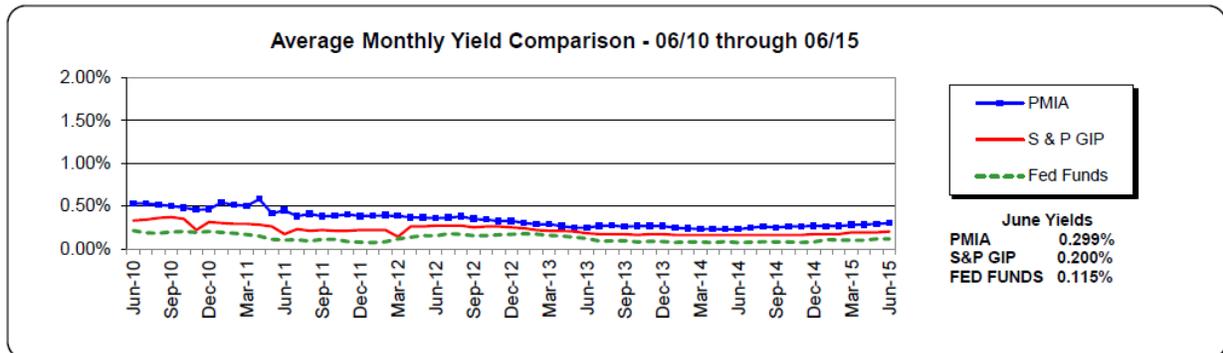
April 2010 – April 2015



May 2010 – May 2015

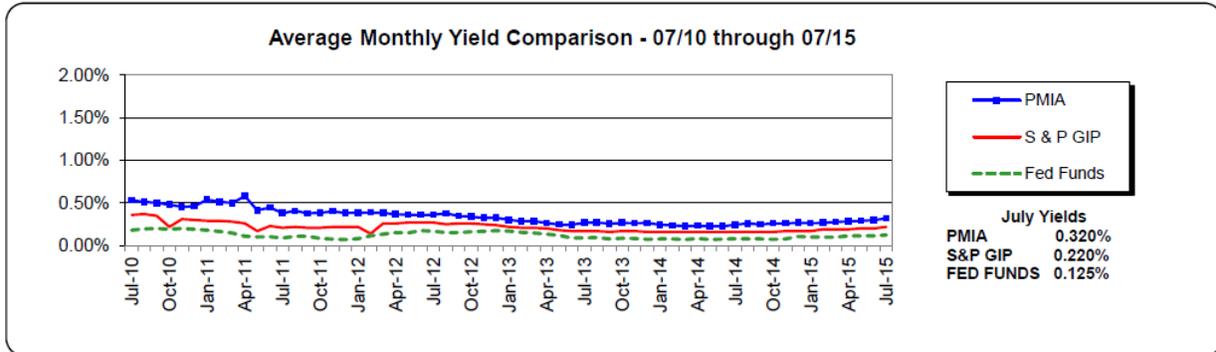


June 2010 – June 2015

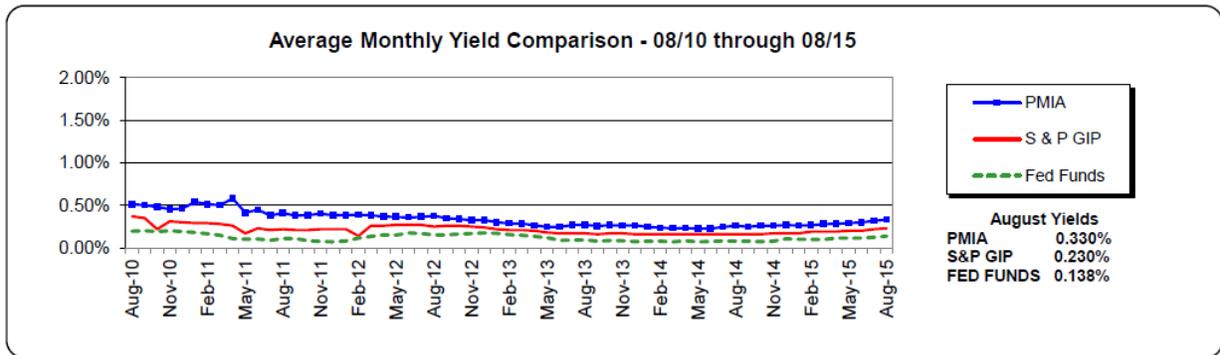


Appendix I – Pooled Money Investment Account (PMIA), Standard and Poor’s Government Investment Pool (S&P GIP), and Federal Funds Average Monthly Yield Comparison – Continued

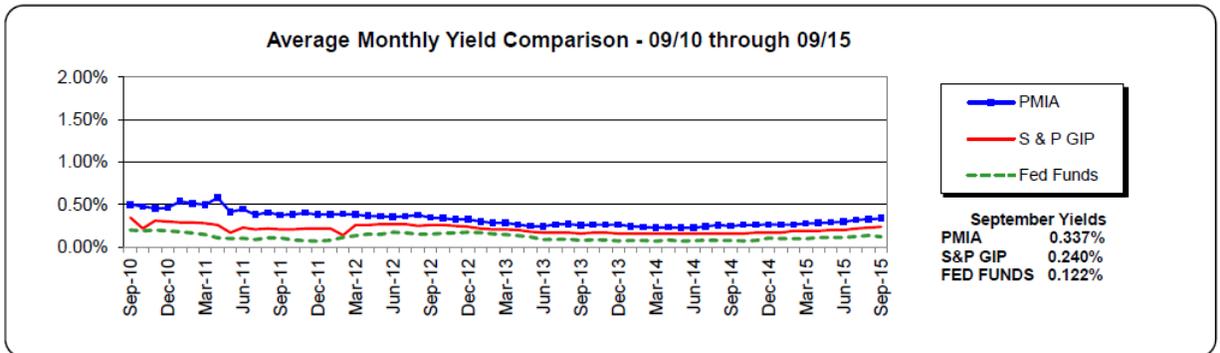
July 2010 – July 2015



August 2010 – August 2015

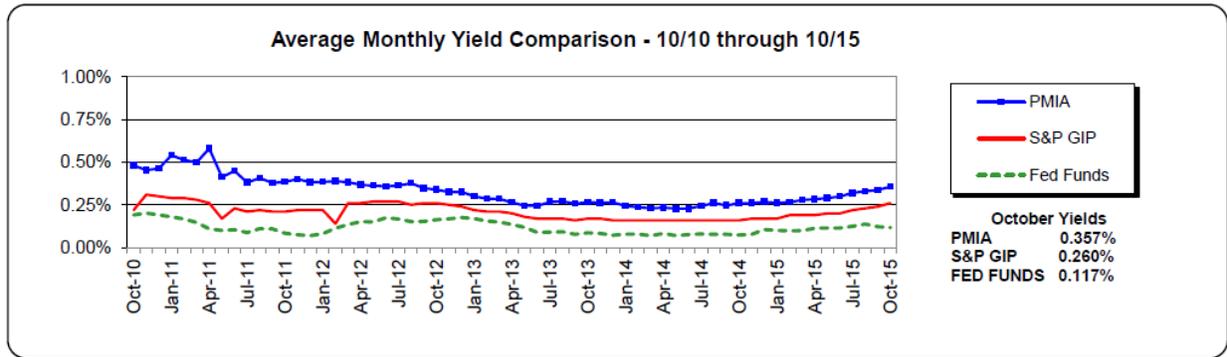


September 2010 – September 2015

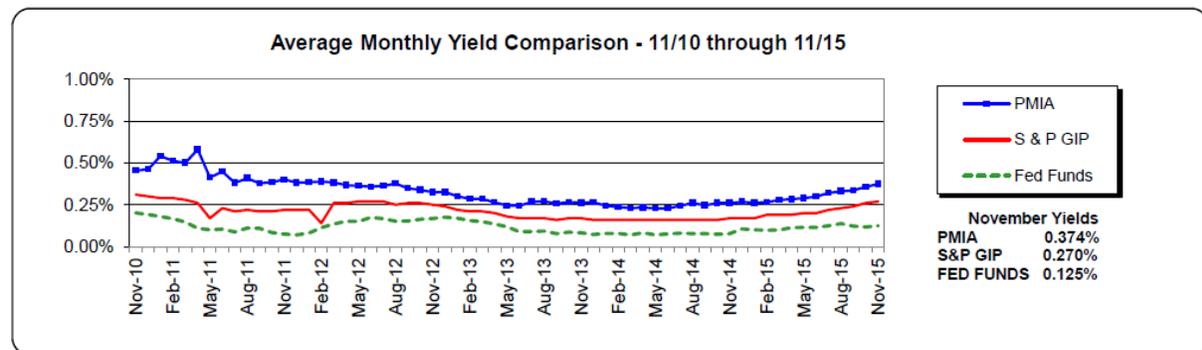


Appendix I – Pooled Money Investment Account (PMIA), Standard and Poor’s Government Investment Pool (S&P GIP), and Federal Funds Average Monthly Yield Comparison – Continued

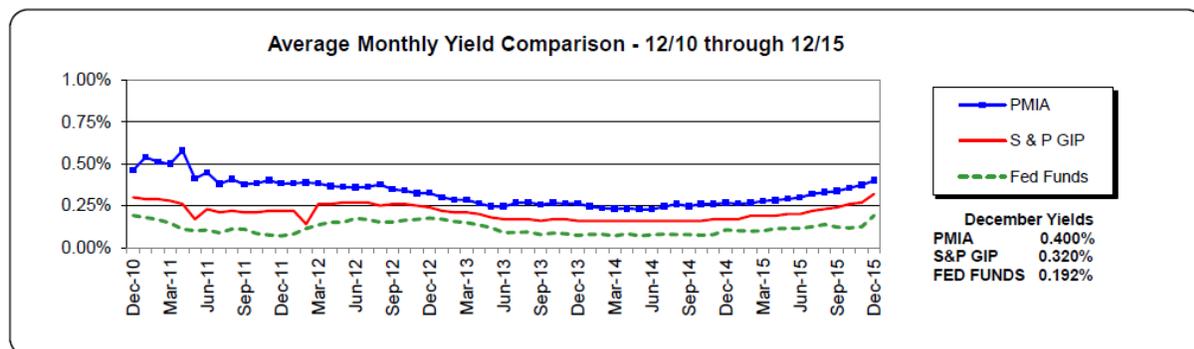
October 2010 – October 2015



November 2010 – November 2015



December 2010 – December 2015





California Public Employees' Retirement System
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Sacramento, CA 94229-2701
www.calpers.ca.gov