

CalPERS HMO Health Plan Benefits Summary

Category Description	Anthem Blue Cross		Blue Shield		Health Net		Sharp	United HealthCare	Kaiser Permanente
	Select	Traditional	Access+	Trio	Salud y Mas	SmartCare			
Calendar Year Deductible	N/A		N/A		N/A		N/A	N/A	N/A
Maximum Calendar Year Co-Pay									
Individual	\$1,500 (see EOC for other items not covered toward co-pay max limit. Co-pay excludes pharmacy)								
Family	\$3,000 (see EOC for other items not covered toward co-pay max limit. Co-pay excludes pharmacy)								
Lifetime Maximum Benefit	N/A		N/A		N/A		N/A	N/A	N/A
Hospital Admission Deductible									
Per Admission	N/A		N/A		N/A		N/A	N/A	N/A
Hospital									
Inpatient (medical & behavioral)	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Outpatient Services (medical & behavioral)	No Charge		No Charge		No Charge		No Charge	No Charge	\$15
Outpatient Surgery	No Charge		No Charge		No Charge		No Charge	No Charge	\$15
Emergency Services	\$50 (waived if admitted as inpatient or observation as an outpatient)								
Ambulance Services	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Physicians Services									
Office Visits	\$15		\$15		\$15		\$15	\$15	\$15
Urgent Care Visits	\$15		\$15		\$15		\$15	\$15	\$15
Inpatient Visits	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Outpatient Visits	\$15		\$15		\$15		\$15	\$15	\$15
Periodic Health Exams/Preventive Care	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Annual Gynecological Exam	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Immunization/Inoculation	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Allergy Testing	No Charge		No Charge		No Charge		No Charge	No Charge	\$15
Allergy Treatment	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Baby Well Care	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Pregnancy & Maternity Care	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Vision Exam/Screening	No Charge (varies by plan for age 18 and over and may be limited)								
Diabetes Prevention	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab	No Charge		No Charge		No Charge		No Charge	No Charge	May require co-pay
Prescription Drugs									
Retail Pharmacy (less than 30 days)	Generic: \$5 Preferred: \$20 Non-Preferred: \$50								
Retail Pharmacy Maintenance Medication filled after 2nd fill (i.e. medication 60+ days)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30-day supply)								
Mail Order Pharmacy Program	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90-day supply for maintenance medication)								
Maximum co-pay per person per year	\$1,000 (excludes non-preferred brands)								
Occupational / Physical / Speech Therapy									
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Outpatient (office and home visits)	\$15		\$15		\$15		\$15	\$15	\$15
Durable Medical Equipment	No Charge		No Charge		No Charge		No Charge	No Charge	No Charge
Acupuncture	\$15 per visit (acupuncture/chiropractic; combined 20 visits per calendar year)								
Chiropractic									

CalPERS PPO Health Plan Benefits Summary

Category Description	PERS Select		PERS Choice		PERS Care	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible^o	Individual \$1,000 / Family \$2,000 (not transferable between plans)		Individual \$500 / Family \$1,000 (not transferable between plans)			
Maximum Calendar Year Co-Pay	Individual \$3,000/Family \$6,000	N/A	Individual \$3,000/Family \$6,000	N/A	Individual \$2,000/Family \$4,000	N/A
Lifetime Maximum Benefit	N/A				N/A	
Hospital Admission Deductible						
Per Admission	N/A		N/A		\$250	
Hospital						
Inpatient (medical & behavioral)						
Outpatient Services (medical & behavioral)	20% *	40%	20%	40%	10%	40%
Outpatient Surgery						
Emergency Room Deductible	\$50 (applies to hospital emergency room charges only)					
Emergency Services	20% (applies to other services rendered)		20% (applies to other services rendered)		10% (applies to other services rendered)	
Non-Emergency Services (waived if admitted as inpatient or for observation as an outpatient)	20% (payment for physician charges only; not emergency room)	40% (payment for physician charges only; not emergency room)	20% (payment for physician charges only; not emergency room)	40% (payment for physician charges only; not emergency room)	10% (payment for physician charges only; not emergency room)	40% (payment for physician charges only; not emergency room)
Ambulance Services	20%	40%	20%	40%	10%	40%
Physicians Services						
Office Visits	\$35 (\$10 for primary physician)	40%	\$20 (\$35 for specialist)	40%	\$20 (\$35 for specialist)	40%
Urgent Care Visits	\$35	40%	\$35	40%	\$35	40%
Outpatient Visits	\$20	40%	\$20	40%	\$20	40%
Inpatient Visits	20%	40%	20%	40%	10%	40%
Periodic Health Exams/Preventive Care	No Charge	40%	No Charge	40%	No Charge	40%
Annual Gynecological Exam	No Charge	40%	No Charge	40%	No Charge	40%
Immunization/Inoculation	No Charge	40%	No Charge	40%	No Charge	40%
Allergy Testing	20%	40%	20%	40%	10%	40%
Allergy Treatment	20%	40%	20%	40%	10%	40%
Baby Well Care	No Charge	40%	No Charge	40%	No Charge	40%
Pregnancy & Maternity Care	20%	40%	20%	40%	10%	40%
Diabetes Prevention	No Charge	40%	No Charge	40%	No Charge	40%
Infertility Testing/Treatment	Not Covered					
Diagnostic X-Ray/Lab	20%	40%	20%	40%	10%	40%
Prescription Drugs						
Retail Pharmacy (less than 30 days)	Generic: \$5 Preferred: \$20 Non-Preferred: \$50					
Retail Pharmacy Maintenance Medication filled after 2nd fill (i.e. medication 60+ days)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30-day supply)					
Mail Order Pharmacy Program	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90-day supply for maintenance medication)					
Maximum co-pay per person per year	\$1,000					
Occupational / Physical / Speech Therapy						
Inpatient (hospital or skilled nursing facility)	No Charge					
Outpatient (office and home visits)	20%	20% - 40%	20%	20% - 40%	10%	10% - 40%
Durable Medical Equipment	20%	40%	20%	40%	10%	40%
Acupuncture						
Chiropractic	\$15 per visit (acupuncture/chiropractic: combined 20 visits per calendar year)					

^o Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include: getting a biometric screening (\$100 credit); receiving a flu shot (\$100 credit); getting a non-smoking certification (\$100 credit); getting a virtual second opinion (\$100 credit); and getting a condition care certification (\$100 credit).

* Coinsurance waived for deliveries if enrolled in Future Moms Program