

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.
All benefits subject to regulatory approval.

BENEFITS	EPO & HMO Basic Plans						
	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Calendar Year Deductible							
Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)							
Individual	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)
Family	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)
Hospital (including Mental Health and Substance Abuse)							
Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	No Charge

Western Health Advantage HMO	CCPOA (Association Plan)

BENEFITS	PPO Basic Plans							
	PERS Gold		PERS Platinum		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO

Calendar Year Deductible

N/A	N/A
N/A	N/A

Individual	\$1,000 ^{1,3}	\$500 ³	N/A	\$300	\$600
Family	\$2,000 ^{1,3}	\$1,000 ³	N/A	\$900	\$1,800

Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)

\$1,500 (copay)	\$1,500 (copay)
\$3,000 (copay)	\$4,500 (copay)

Individual	\$3,000 (coinsurance)	Unlimited	\$2,000 (coinsurance)	Unlimited	\$3,000 (coinsurance)	Unlimited	\$2,000	Unlimited
Family	\$6,000 (coinsurance)	Unlimited	\$4,000 (coinsurance)	Unlimited	\$6,000 (coinsurance)	Unlimited	\$4,000	Unlimited

Hospital (including Mental Health and Substance Abuse)

N/A	N/A
No Charge	\$100/admission
No Charge	\$50

Deductible (per admission)	N/A		\$250		N/A		N/A	
Inpatient	20% ²	40% ⁴	10%	40% ⁴	10%	Varies	20%	20% ⁴
Outpatient Facility/Surgery Services	20%	40% ⁴	10%	40% ⁴	10%	40% ⁴	20%	20% ⁴

¹ 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).

² Coinsurance waived for deliveries if enrolled in Future Moms Program.

³ Deductible is transferable between PERS Gold and PERS Platinum.

⁴ Of the allowable amount as defined in the EOC.

CalPERS Health Plan Benefit Comparison—Basic Plans, *Continued*

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	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Emergency Services							
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Non-Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Physician Services (including Mental Health and Substance Abuse)							
Office Visits (copay for each service provided)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia	No Charge	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	No Charge	No Charge

		PPO Basic Plans							
Western Health Advantage HMO	CCPOA (Association Plan)	PERS Gold		PERS Platinum		CAHP (Association Plan)		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
BENEFITS									
Emergency Services									
N/A	N/A	Emergency Room Deductible		Emergency		Non-Emergency			
\$50	\$75	\$50 (applies to hospital emergency room facility charge only)		20% (applies to other services such as physician, x-ray, lab, etc.)		20% 40% (payment for physician charges only; emergency room facility charge is not covered)		N/A	
\$50	\$75	\$50 (applies to hospital emergency room charges only)		10% (applies to other services such as physician, x-ray, lab, etc.)		10% 40% (payment for physician charges only; emergency room facility charge is not covered)		20%	
		\$50 (copay reduced to \$25 if admitted on an inpatient basis)		10% (applies to other services such as physician, x-ray, lab, etc.)		\$50+10% \$50+40% (copay reduced to \$25 if admitted on an inpatient basis)		50% (for non-emergency services provided by hospital emergency room)	
Physician Services (including Mental Health and Substance Abuse)									
\$15	\$15	Office Visits (copay for each service provided)		Inpatient Visits		Outpatient Visits		Urgent Care Visits	
No Charge	No Charge	\$35 ¹ 40% ³		20% 40% ³		\$35 40% ³		\$35 40% ³	
\$15	\$15	\$35 40% ³		\$20 40% ³		\$20 40% ³		\$20 40% ³	
\$15	\$15	\$35 40% ³		\$35 40% ³		\$20 40% ³		\$35 20% ³	
No Charge	No Charge	No Charge 40% ³		No Charge 40% ³		No Charge 40% ³		No Charge	
No Charge	No Charge	20% 40% ³		10% 40% ³		10% 40% ³		20% 20% ³	
Diagnostic X-Ray/Lab									
No Charge	No Charge	20% 40% ³		10% 40% ³		10% 40% ³		20% 20% ³	

¹ Reduced to \$10 when seen by primary physician² \$35 for specialist visit³ Of the allowable amount as defined in the EOC

CalPERS Health Plan Benefit Comparison—Basic Plans, *Continued*

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BENEFITS	EPO & HMO Basic Plans						
	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Prescription Drugs							
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic/Tier 1 ¹ : \$5 Preferred Brand/ Tier 2 ¹ : \$20 Non-Preferred/ Tier 3 ¹ : \$50 Tier 4 ¹ : \$30	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic: \$5 Brand: \$20	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50
Retail Preferred Pharmacy Maintenance Medications (90-day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic/Tier 1 ¹ : \$10 Preferred Brand/ Tier 2 ¹ : \$40 Non-Preferred/ Tier 3 ¹ : \$100 Tier 4 ¹ : \$60	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	N/A	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
Mail Order Pharmacy Program (not to exceed 90- day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic/Tier 1 ¹ : \$10 Preferred Brand/ Tier 2 ¹ : \$40 Non-Preferred/ Tier 3 ¹ : \$100 Tier 4 ¹ : \$60	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
Mail order maximum copayment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	\$1,000
Durable Medical Equipment							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

¹ Tier Formulary is for BSC Trio HMO only

Tier 1 refers to medications classified as 'Generic'; Tier 2 refers to medications classified as "Preferred Brand"; and Tier 3 refers to medications classified as "Non-Preferred Brand".

		PPO Basic Plans							
Western Health Advantage HMO	CCPOA (Association Plan)	PERS Gold		PERS Platinum		CAHP (Association Plan)		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
BENEFITS									
Prescription Drugs									
N/A	Tier 2, 3, and 4: \$50 (not to exceed \$150/family)	Deductible		N/A	N/A	N/A	N/A	N/A	
Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$10 Tier 2: \$25 Tier 3 and 4: \$50	Retail Pharmacy (30-day supply)		Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$30 Tier 2: \$75 Tier 3 and 4: \$150	Retail Preferred Pharmacy Maintenance Medications		Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Formulary: \$40 Non-Formulary: \$100		N/A	
Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$30 Tier 2: \$75 Tier 3 and 4: \$100	Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)		Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Formulary: \$40 Non-Formulary: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75	N/A
\$1,000	N/A	Mail order maximum copayment per person per calendar year		\$1,000	\$1,000	N/A		N/A	
Durable Medical Equipment									
No Charge	No Charge	20%	40% ¹	10%	40% ¹	10%	40% ¹	20%	20% ¹
		(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at \$1,000 or more)					

¹ Of the allowable amount as defined in the EOC

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	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Infertility Testing/Treatment							
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational / Physical / Speech Therapy							
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Diabetes Services							
Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
Self-management training	\$15	\$15	\$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)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$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/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

Western Health Advantage HMO	CCPOA <i>(Association Plan)</i>
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50% of Covered Charges	50% of Allowed Charges
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No Charge	No Charge
\$15	No Charge

Coverage varies	Coverage varies
\$15	\$15

\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	N/A
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\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: \$50
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BENEFITS	PPO Basic Plans							
	PERS Gold		PERS Platinum		CAHP <i>(Association Plan)</i>		PORAC <i>(Association Plan)</i>	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO

Infertility Testing/Treatment

50%	50%	Not Covered	50%	50% ²
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Occupational / Physical / Speech Therapy

Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		10%	40%	20% (no copay for in-patient PT/OT by a PAR provider)	20% ²
Outpatient (office and home visits)	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	10%	40%	\$15/visit (all other services 20%) ³	20% ²
	(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)			

Diabetes Services

Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20	60% ²	\$20	60% ²

Acupuncture

\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	10%	40% ²	\$15 copay (all other services 20%) ³	20% ²
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Chiropractic

\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	10%	40% ²	\$15/visit (combined 20 visits per calendar year)	20% ²
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¹ \$35 for specialist visit

² Of the allowable amount as defined in the EOC

³ Combined 20 visits per calendar year. Speech therapy is not included in the 20 visit per calendar year combination; see EOC for Speech Therapy benefit.