

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					
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

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		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										
Calendar Year Deductible										
N/A	N/A	Individual	\$1,000 ¹³	\$2,500 ³	\$500 ³	\$2,000 ³	N/A	\$300	\$600	
N/A	N/A	Family	\$2,000 ¹³	\$5,000 ³	\$1,000 ³	\$4,000 ³	N/A	\$900	\$1,800	
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)										
\$1,500 (copay)	\$1,500 (copay)	Individual	\$3,000 (coinsurance)	Unlimited	\$2,000 (coinsurance)	Unlimited	\$3,000 (coinsurance)	Unlimited	\$2,000	\$2,000
\$3,000 (copay)	\$4,500 (copay)	Family	\$6,000 (coinsurance)	Unlimited	\$4,000 (coinsurance)	Unlimited	\$6,000 (coinsurance)	Unlimited	\$4,000	\$4,000
Hospital (including Mental Health and Substance Abuse)										
N/A	N/A	Deductible (per admission)	N/A		\$250		N/A		N/A	
No Charge	\$100/admission	Inpatient	20% ²	40% ⁴	10%	40% ⁴	10%	Varies	20%	20% ⁴
No Charge	\$50	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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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					
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		\$50 (applies to hospital emergency room facility charge only)		\$50 (applies to hospital emergency room charges only)		\$50 (copay reduced to \$25 if admitted on an inpatient basis)		N/A	
\$50	\$75	Emergency		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% (applies to other services such as physician, x-ray, lab, etc.)		20%	
\$50	\$75	Non-Emergency		20%	40%	10%	40%	\$50+10%	\$50+40%	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)		\$35 ¹	40% ³	\$20 ²	40% ³	\$20	40% ³	\$10/\$35 ²	20% ³
No Charge	No Charge	Inpatient Visits		20%	40% ³	10%	40% ³	10%	40% ³	20%	20% ³
\$15	\$15	Outpatient Visits		\$35	40% ³	\$20	40% ³	10%	40% ³	20%	20% ³
\$15	\$15	Urgent Care Visits		\$35	40% ³	\$35	40% ³	\$20	40% ³	\$35	20% ³
No Charge	No Charge	Preventive Services		No Charge	40% ³	No Charge	40% ³	No Charge	40% ³	No Charge	
No Charge	No Charge	Surgery/Anesthesia		20%	40% ³	10%	40% ³	10%	40% ³	20%	20% ³
		Diagnostic X-Ray/Lab									
No Charge	No Charge	20% ⁴	40% ³	10% ⁴	40% ³	10%	40% ³	10%	40% ³	20%	20% ³

¹ Reduced to \$10 when seen by primary physician

² \$35 for specialist visit

³ Of the allowable amount as defined in the EOC

⁴ For lab services only - no charge when using Quest Diagnostic or Labcorp.

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					
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: \$5 Preferred Brand/ Tier 2: \$20 Non-Preferred/ Tier 3: \$50 Tier 4: \$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)	N/A	Generic/Tier 1: \$10 Preferred Brand/ Tier 2: \$40 Non-Preferred/ Tier 3: \$100 Tier 4: \$60	N/A	N/A	N/A	N/A	N/A
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: \$10 Preferred Brand/ Tier 2: \$40 Non-Preferred/ Tier 3: \$100 Tier 4: \$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
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

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							
		PERS Gold		PERS Platinum		CAHP (Association Plan)		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Western Health Advantage HMO	CCPOA (Association Plan)	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	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		
N/A	Tier 1: \$30 Tier 2: \$75 Tier 3 and 4: \$150	Retail Preferred Pharmacy Maintenance Medications (90-day supply)		N/A	N/A	Generic: \$10 Formulary: \$40 Non-Formulary: \$100	N/A		
Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$20 Tier 2: \$50 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)					
Infertility Testing/Treatment									
50% of Covered Charges	50% of Allowed Charges	50%		50%		Not Covered		50%	50% ²

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	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO					
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)

		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
Western Health Advantage HMO	CCPOA (Association Plan)	BENEFITS							
Occupational / Physical / Speech Therapy									
No Charge	No Charge	No Charge		No Charge		10%	40%	20% (no copay for in-patient PT/OT by a PAR provider)	20% ²
\$15	No Charge	20% <small>(pre-certification required for more than 24 visits)</small>	40%; Occupational therapy: 20%	10% <small>(pre-certification required for more than 24 visits)</small>	40%; Occupational therapy: 10%	10% <small>(pre-certification required for more than 24 visits)</small>	40%	\$15 / Office Visit (all other services 20%) ³	20% ²
Diabetes Services									
Coverage varies	No Charge	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
\$15	\$15	\$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)	N/A	\$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% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	\$15 / Office Visit (all other services 20%) ³	20% ²
Chiropractic									
\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: \$50	\$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% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% ²	\$15 / Office Visit (all other services 20%) ³	20% ²

¹ \$35 for specialist visit

² Of the allowable amount as defined in the EOC

³ Combined 20 visits per calendar year. (Occupational/Physical/Chiropractor) Combined 20 visits per calendar year