

CalPERS Health PPO Plans Benefits Summary

Category Description	PERS Select/Choice		PERS Care	
	PPO Select/Choice	Non-PPO Select/Choice	PPO	Non-PPO
Calendar Year Deductible	Individual \$500 / Family \$1,000 (not transferable between plans)		Individual: \$500 / Family \$1,000 (not transferable between plans)	
Maximum Calendar Year Co-pay (excluding pharmacy)	Individual \$3,000/Family \$6,000	N/A	Individual \$2,000 / Family \$6,000	N/A
Lifetime Maximum Benefit	N/A	N/A	N/A	
Per Admission	N/A	N/A	N/A	
Hospital Admission Deductible				
Per Admission	N/A	N/A	\$250	
Hospital				
Inpatient (medical & behavioral)	20-30% (depending on the hospital)	40%	10%	40%
Outpatient Facility Services (medical & behavioral)		40%	10%	40%
Outpatient Surgery		40%	10%	40%
Emergency Room Deductible	\$50			
Emergency Services (applies to other services as physician, x-ray, lab, etc.)	(applies to hospital emergency room charges only; deductible waived if admitted as an inpatient or for observation as an outpatient)			
Emergency	20%	20%	10%	10%
Non-emergency	20%	40%	10%	40%
	(payment for physician charges only; emergency room facility charge for non-emergency service is not covered)			
Ambulance Services	20%	20%	20%	20%
Physician Services				
Office Visits	\$20	40%	\$20	40%
	(medical & behavioral) (more than one co-pay may apply during an office visit if multiple services are provided)			
Inpatient Hospital Visits (medical & behavioral)	20%	40%	10%	40%
Outpatient Hospital Visits (medical & behavioral)	\$20 per visit	40%	\$20 per visit	40%
Urgent Care Visits	\$20 per visit	40%	\$20 per visit	40%
Periodic Health Exam/Preventive Care	No Charge	40%	No Charge	40%
Annual Gynecological Exam	No Charge	40%	No Charge	40%
Immunization/inoculation	No Charge	40%	No Charge	40%
Well Baby Care	No Charge	40%	No Charge	40%
Pregnancy & Maternity Care (includes pre-natal and post natal visits)	20%	40%	10%	40%
Allergy Testing	20%	40%	10%	40%
Allergy Treatment	20%	40%	10%	40%
Vision Exam/Screening	Not Covered			
Hearing Exam/Screening	20%	40%	10%	40%
Surgery/Anesthesia	20%	40%	10%	40%
Diagnostic X-Ray/Lab	20%	40%	10%	40%
Prescription Drugs				
Retail Pharmacy (less than 30 days)	Generic: \$10 Preferred: \$25 Non-Preferred: \$75		Generic: \$10 Preferred: \$25 Non-Preferred: \$75	
Mail Order Pharmacy Program	Generic: \$10 Preferred: \$25 Non-Preferred: \$75		Generic: \$10 Preferred: \$25 Non-Preferred: \$75	
Maximum co-payment per person per calendar year	\$1000 (excludes non-preferred brands)			
Infertility Testing/Treatment	Not Covered			
Physical Therapy				
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge	
Outpatient (office and home visits)	20%	40%	10%	40%
Acupuncture	20%	40%	10%	40%
Chiropractic	20%	40%	10%	40%

CalPERS Health HMO Plans Benefits Summary

Category Description	Blue Shield HMO		Kaiser Permanente
	Blue Shield Access	Blue Shield Netvalue	
Calendar Year Deductible	N/A		N/A
Maximum Calendar Year Co-pay (excluding pharmacy)			
Individual	\$1,500 (see EOC for other items not counted toward co-pay max limit)		
Family	\$3,000 (see EOC for other items not counted towards co-pay max limit)		
Lifetime Maximum Benefit	N/A		N/A
Hospital Admission Deductible			
Per Admission	N/A		N/A
Hospital			
Inpatient (medical & behavioral)	No Charge		No Charge
Outpatient Facility Services (medical & behavioral)	No Charge		\$15
Outpatient Surgery	No Charge (refer to EOC, exceptions may apply)		\$15
Emergency Services	\$50 (waived if admitted as inpatient or observation as an outpatient)		\$50 (waived if admitted as inpatient or observation as an outpatient)
Ambulance Services	No Charge		No Charge
Physician Services			
Office Visits	\$15 (medical & behavioral) (more than one co-pay may apply during an office visit if multiple services are provided)		\$15
Inpatient Hospital Visits (medical & behavioral)	No Charge		No Charge
Outpatient Hospital Visits (medical & behavioral)	\$15		\$15
Urgent Care Visits	\$15		\$15
Periodic Health Exam/Preventive Care	No Charge		No Charge
Annual Gynecological Exam	No Charge		No Charge
Immunization/inoculation	No Charge		No Charge
Well Baby Care	No Charge		No Charge
Pregnancy & Maternity Care (includes pre-natal and first post natal visits)	No Charge		No Charge
Allergy Testing	No Charge		\$15
Allergy Treatment	No Charge		No Charge
Vision Exam/Screening	No Charge (varies by plan for age 18 and over and may be limited)		No Charge
Hearing Exam/Screening	No Charge		No Charge
Surgery/Anesthesia	No Charge		No Charge for inpatient; \$15 for outpatient
Diagnostic X-Ray/Lab	No Charge		No Charge (some procedures may require a co-pay)
Prescription Drugs			
Retail Pharmacy (less than 30 days)	Generic: \$5 Preferred: \$15 Non-Preferred: \$45		Generic: \$5 Preferred: \$15
Retail Pharmacy Maintenance Medications filled after 2nd fill (i.e., a medication taken longer than 60 days)	Generic: \$10 Brand Formulary: \$25 Not formulary: \$75 (not to exceed 30-day supply)		N/A
Mail Order Pharmacy Program	Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$75		Generic: \$5 Brand: \$15 (up to 30-day supply) Generic: \$10 Brand: \$30 (31-100 day supply)
Maximum co-payment per person per calendar year	\$1000 (excludes non-preferred brands)		N/A
Physical Therapy			
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge
Outpatient (office and home visits)	\$15		\$15
Acupuncture	Not Covered (alternate care discounts of 25% or more)		\$15 (when medically necessary; discounts available up to 25% off)
Chiropractic	Not Covered (discounts available up to of 25% off)		Not Covered (alternate care discounts of 25% or more)