## 2018 CalPERS Health Plan Benefit Comparison

## **PPO PLANS**

	PERS Select		PERS Choice		PERSCare						
BENEFITS	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO					
	110			Non-110	110	Non-FFO					
			ear Deductible								
Individual	The second secon	500		500	\$500						
		e between plans)		e between plans)	(not transferable between plans)						
Family	· ·	000	· ·	000	\$1000						
(not transferable between plans)			i i	e between plans)	(not transferable between plans)						
	Max	imum Calendar Year	Co-pay (excluding pha	rmacy)							
Individual	\$3,000	N/A	\$3,000	N/A	\$2,000	N/A					
marrada	(co-insurance)	10/1	(co-insurance)	14/11	(co-insurance)	1471					
Family	\$6,000	N/A	\$6,000	N/A	\$4,000	N/A					
	(co-insurance)		(co-insurance)		(co-insurance)	1012					
Hospital (including Mental Health and Substance Abuse)											
Deductible (per admission)	20-30%	/A	N	/A	\$2	50					
Inpatient	(hospital tiers)	40%	20%	40%	10%	40%					
Outpatient/ Facility/	20-30%	40%	20%	40%	10%	40%					
Surgery Services	(hospital tiers)			40 / 0	10 / 0	4070					
	¢.	Emerger 50	ncy Services	50	ę.	50					
Emergency Room Deductible		al emergency room		al emergency room		l emergency room					
	charges only)		charges only)		charges only)						
Emergency	20	)%	20	1%	10%						
(co-pay waived if admitted as an inpatient or for observation as an outpatient)	(applies to other services lab,			such as physicians, x-ray, etc)		such as physicians, x-ray, etc)					
Non-En	20%	40%	20%	40%	10%	40%					
Non-Emergency (co-pay waived if admitted as an inpatient or for											
observation as an outpatient)		charges only, ER facility ot covered)		charges only, ER facility ot covered)		charges only, ER facility ot covered)					
*****					charge is n	or covereu)					
O00 771 to	Physician	Services (including M	ental Health and Subst	tance Abuse)							
Office Visits (co-pay for each service provided)	\$20	40%	\$20	40%	\$20	40%					
Inpatient Visits	20%	40%	20%	40%	10%	40%					
Outpatient Visits	\$20	40%	\$20	40%	\$20	40%					
Urgent Care Visits	\$20	40%	\$20	40%	\$20	40%					
Vision Exam/Screening	Not Co	overed		overed	Not C						
Surgery/Anesthesia	20%	40%	20%	40%	10%	40%					
			c X-Ray/Lab	T							
	20%	40%	20%	40%	10%	40%					
W 1 (0)			otion Drugs	/4		/A					
Deductible	N/	/A	N	/A	N <sub>i</sub>	/A					
	Generic: \$5		Generic: \$5		Generic: \$5						
1		ric: \$5	Gener								
Retail Pharmacy	Preferr			red: \$20	Preferr						
Retail Pharmacy (not to exceed 30-day supply)	Preferr		Preferi		Non-Prefe	erred: \$50					
_	Preferr	red: \$20	Preferi	red: \$20	Non-Prefe						
(not to exceed 30-day supply)	Preferr Non-Prefe	red: \$20 erred: \$50	Preferi Non-Pref	red: \$20 erred: \$50	Non-Prefe (not to exceed Gener	erred: \$50 34 day supply) ic: \$10					
(not to exceed 30-day supply)  Retail Pharmacy Maintenance Medications filed	Preferr Non-Prefe Generi	red: \$20 erred: \$50	Preferi Non-Pref Gener	red: \$20	Non-Prefe (not to exceed Gener Preferr	erred: \$50 34 day supply) ic: \$10 red: \$40					
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(not to exceed 30-day supply)  Retail Pharmacy Maintenance Medications filed after 2nd fill (i.e. a medication taken longer than 60 days) (not to exceed 30-day supply)  Mail Order Pharmacy Program (not to exceed 90 day supply for maintenance drugs)  Mail order maximum co-payment per person per calendar year  Durable Medical Equipment  Infertility Testing/Treatment  Inpatient (hospital or skilled nursing facility)  Outpatient (office and home visits)  Glucose monitors, test strips Self-management training	Preferr Non-Prefe  Generi Preferr Non-Prefe  Generi Preferr Non-Prefe  \$1,0  20% (pre-certification require visi  Coverag \$2  \$15/visit (acupuncture/chiropracticalenda)	red: \$20 erred: \$50  ic: \$10 ed: \$40 erred: \$100  ic: \$10 ed: \$40 orred: \$100  Durable Med 40%  uired for equipment)  Infertility Te  overed  Occupational / Phy tharge  40%; Occupational therapy: 20% ed for more than 24 its)  Diabete ge Varies  Occupational therapy: 20% do for more than 24 its)  Chir 40% ic combined 20 visits per ar year)  Chir 40% ic combined 20 visits per	Preferr Non-Prefer  Gener Preferr Non-Prefer  Gener Preferr Non-Prefer  \$1,4  lical Equipment 20% (pre-certification require sting/Treatment  Not C  sical / Speech Therapy No C  20% (pre-certification require vis es Services  Coverag \$2  suncture \$15/visit (acupuncture/chiropract calenda opractic \$15/visit (acupuncture/chiropract	red: \$20 erred: \$50 ic: \$10 ed: \$40 rred: \$100 ic: \$10 ed: \$40 rred: \$100  000  40% uired for equipment)  overed  tharge  40%; Occupational therapy: 20% ed for more than 24 its) ge Varies 20  40% ic combined 20 visits per ar year)	Non-Prefe (not to exceed  Gener Preferr Non-Prefe (not to exceed  Gener Preferr Non-Prefe \$1,0  10% (pre-certification required mode)  Not C  No C  Coverag \$2  \$15/visit (acupuncture/chiropract calenda	erred: \$50 34 day supply) ic: \$10 red: \$40 rred: \$100 34 day supply) ic: \$10 ed: \$40 rred: \$100 000  40% d for equipment \$1,000 or ree)  overed  harge  40% ic combined 20 visits per ar year)  40% ic combined 20 visits per ar year)					
(not to exceed 30-day supply)  Retail Pharmacy Maintenance Medications filed after 2nd fill (i.e. a medication taken longer than 60 days) (not to exceed 30-day supply)  Mail Order Pharmacy Program (not to exceed 90 day supply for maintenance drugs)  Mail order maximum co-payment per person per calendar year  Durable Medical Equipment  Infertility Testing/Treatment  (hospital or skilled nursing facility)  Outpatient (office and home visits)  Glucose monitors, test strips Self-management training  Acupuncture	Preferr Non-Prefe  Generi Preferr Non-Prefe  Generi Preferr Non-Prefe  \$1,0  20% (pre-certification require visi  Coverag \$2  \$15/visit  (acupuncture/chiropract calenda	red: \$20 erred: \$50  ic: \$10 ed: \$40 erred: \$100  ic: \$10 ed: \$40 orred: \$100  Durable Med 40%  uired for equipment)  Infertility Te  overed  Occupational / Phy tharge  40%; Occupational therapy: 20% ed for more than 24 its)  Diabete ge Varies  Occupational therapy: 20% do for more than 24 its)  Chir 40% ic combined 20 visits per ar year)  Chir 40% ic combined 20 visits per	Preferr Non-Prefer  Gener Preferr Non-Prefer  Gener Preferr Non-Prefer  \$1,4  lical Equipment 20% (pre-certification require sting/Treatment  Not C  sical / Speech Therapy No C  20% (pre-certification require vis es Services  Coverag \$2  suncture \$15/visit (acupuncture/chiropract calenda opractic \$15/visit (acupuncture/chiropract	red: \$20 erred: \$50 ic: \$10 ed: \$40 rred: \$100 ic: \$10 ed: \$40 rred: \$100 000  40% uired for equipment)  overed  40%; Occupational therapy: 20% d for more than 24 its) ge Varies 20  40% ic combined 20 visits per ar year)	Non-Prefe (not to exceed  Gener Preferr Non-Prefe (not to exceed  Gener Preferr Non-Prefe \$1,0  10% (pre-certification required mode)  Not C  No C  Coverag \$2  \$15/visit (acupuncture/chiropract calenda	erred: \$50 34 day supply) ic: \$10 red: \$40 rred: \$100 34 day supply) ic: \$10 ed: \$40 rred: \$100 000  40% d for equipment \$1,000 or ore)  overed  harge  40% ge Varies 20  40% ic combined 20 visits per ar year)					

## 2018 CalPERS Health Plan Benefit Comparison

## **HMO PLANS**

	Anthem Blue Cross		Blue Shield Health Net		h Net	Kaiser	UnitedHealthcare					
BENEFITS	Select	Traditional	Access+	Salud y Más	SmartCare	Permanente	SignatureValue					
	Sciece	Traditional			Smartcare		Alliance					
Calendar Year Deductible												
Individual	N/A	N/A N/A N/A		Ά	N/A	N/A						
Family	N/A	L	N/A	N/A		N/A	N/A					
Maximum Calendar Year Co-pay (excluding pharmacy)												
Individual	\$1,50	00	\$1,500	\$1,5	500	\$1,500	\$1,500					
Family	\$3,000		\$3,000	\$3,000		\$3,000	\$3,000					
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					
Outpatient/ Facility/ Surgery Services	No Cha	arge	No Charge	No Ch	narge	\$15	No Charge					
			Emergency Se	ervices								
Emergency Room Deductible	N/A		N/A	N/.	Ά	N/A	N/A					
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	)	\$50	\$50		\$50	\$50					
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	)	\$50	\$50		\$50	\$50					
		Physic	ian Services (including Mental	Health and Sub	stance Abuse)							
Office Visits (co-pay for each service provided)	\$15	;	\$15	\$1	.5	\$15	\$15					
Inpatient Visits	No Cha	arge	No Charge	No Cl	harge	No Charge	No Charge					
Outpatient Visits	\$15		\$15	\$1		\$15	\$15					
Urgent Care Visits	\$15		\$15	\$1		\$15	\$15					
Vision Exam/Screening Surgery/Anesthesia	No Cha No Cha		No Charge No Charge	No Cl No Cl		No Charge No Charge	No Charge No Charge					
Sui gery/Aliestilesia	110 Cm	arge	Diagnostic X-R		imi ge	No Charge	No Charge					
	No Cha	arge	No Charge	No Cl	harge	No Charge	No Charge					
			Prescription 1	Drugs								
Deductible	N/A	<u> </u>	N/A	N/	A	N/A	N/A					
Retail Pharmacy (not to exceed 30-day supply)	Generio Brand Formo Non-Formu	ulary: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Gener Brand Forn Non-Form	nulary: \$20	Generic: \$5 Brand: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50					
Retail Pharmacy Maintenance Medications filed after 2nd fill (i.e. a medication taken longer than 60 days) (not to exceed 30-day supply)	Generic Brand Form Non-Formul	ulary: \$40	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generi Brand Forn Non-Formu	nulary: \$40	N/A	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100					
Mail Order Pharmacy Program (not to exceed 90 day supply for maintenance drugs)	Generic Brand Form Non-Formul	ulary: \$40	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100		Generic: \$10 Brand: \$40 (31-100 day supply)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100					
Mail order maximum co-payment per person per calendar year	\$1,00	00	\$1,000	\$1,0	000	N/A	\$1,000					
* · · · · * · · · · · · · · · · · · · ·			Durable Medical 1	Equipment								
Durable Medical Equipment	No Cha	arge	No Charge	No Cl	harge	No Charge	No Charge					
			Infartility Testing	Treatment								
	50% of C	overed	Infertility Testing/	1 reatment 50% of 0	Covered	50% of Covered	50% of Covered					
Infertility Testing/Treatment	Charg		Charges	Char		Charges	Charges					
			Occupational / Physical /		-							
Inpatient (hospital or skilled nursing facility)	No Cha	arge	No Charge	No Cl		No Charge	No Charge					
Outpatient (office and home visits)	\$15	;	\$15	\$1	.5	\$15	\$15					
			Diabetes Ser									
Glucose monitors, test strips	No Cha	-	No Charge	No Cl	-	No Charge	No Charge					
Self-management training	\$15		\$15 Acupuncti	\$1	.5	\$15	\$15					
Acupuncture	\$15/vi (acupuncture/ c combined 20 visit year	chiropractic; s per calendar	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/- (acupuncture/ combined 20 vis yea	chiropractic; its per calendar	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiroropractic; combined 20 visits per calendar year)					
Chiropractic           \$15/visit         \$15/visit												
Chiropractic	(acupuno chiropractic; com	cture/ abined 20 visits	(acupuncture/ chiropractic; combined 20 visits	(acupui chiropractic; coi	ncture/ mbined 20 visits	(acupuncture/ chiropractic; combined 20 visits	(acupuncture/ chiroropractic; combined 20					
1	per calenda	ar year)	per calendar year)	per caleno	dar year)	per calendar year)	visits per calendar year)					