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 EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
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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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	Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	N/A		$300	$600
N/A	N/A	Family	$2,000 [1,3]	$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*

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 EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
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

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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
		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% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%	$50+10% (copay reduced to $25 if admitted on an inpatient basis)	$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]	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.

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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
		Prescription Drugs								
N/A	Tier 2, 3, and 4: $50 (not to exceed $150/family)	Deductible	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% (pre-certification required for specific equipment)	40%[1] (pre-certification required for specific equipment)	10% (pre-certification required for the purchase of equipment priced at $1,000 or more)	40%[1] (pre-certification required for the purchase of equipment priced at $1,000 or more)	10%	40%[1]	20%	20%[1]
		Infertility Testing/Treatment								
50% of Covered Charges	50% of Allowed Charges		50%		50%		Not Covered		50%	50%[2]

[1] Of the allowable amount as defined in the EOC

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

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 EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
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)

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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
		Occupational / Physical / Speech Therapy								
No Charge	No Charge	Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		10%	40%	20% (no copy for in-patient PT/OT by a PAR provider)	20% [2]
$15	No Charge	Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%	10% (pre-certification required for more than 24 visits)	40%	$15 / Office Visit (all other services 20%) [3]	20% [2]
		Diabetes Services								
Coverage varies	No Charge	Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
$15	$15	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)	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