HMO MEDICAL COVERAGE

CalPERS	Anthem Select	Anthem Traditional	Blue Shield Access+	Kaiser Traditional	UHC Alliance	UHC Harmony
In-Network Only						
Annual Deductible	None	None	None	None	None	None
Routine & Specialist Office Visit	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Preventive Care Services	No charge	No charge	No charge	No charge	No charge	No charge
Urgent Care Visit	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Emergency Room Visit	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Diagnostic X-Ray / Lab	No charge	No charge	No charge	No charge	No charge	No charge
Durable Medical Equipment	No charge	No charge	No charge	No charge	No charge	No charge
Inpatient Hospitalization	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Facility / Surgery Services	No charge	No charge	No charge	$15 copay	No charge	No charge
Surgery / Anesthesia	No charge	No charge	No charge	No charge	No charge	No charge
Occupational / Physical / Speech Therapy	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Acupuncture / Chiropractic	$15 copay 20 combined visits	$15 copay 20 combined visits	$15 copay 20 combined visit	$15 copay 20 combined visits	$15 copay 20 combined visits	$15 copay 20 combined visits
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
Max Calendar Year Copay/Coinsurance (excluding pharmacy)	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam
Prescription Drugs (Generic / Preferred / Non-Preferred)						
Retail Pharmacy [1] (not to exceed 30-day supply)	$5 / $20 / $50	$5 / $20 / $50	$5 / $20 / $50	$5 / $20 / NA	$5 / $20 / $50	$5 / $20 / $50
Mail Order Pharmacy (not to exceed 90-day supply)	$10/$40/$100	$10/$40/$100	$10/$40/$100	$10/$40/NA	$10/$40/$100	$10/$40/$100

Above is a snapshot summary. Refer to the plan's Evidence of Coverage (EOC) for the full summary of coverage information.

[1] Review your plan to ensure if Retail Pharmacy Maintenance Medications require a Home Delivery Opt-Out form to be completed to continue to have prescriptions filled at retail. Plans that do not require Home Delivery for Maintenance Medications may be subject to a higher copay after the 2nd fill.

NOTE: Only plans available in Santa Clara, San Mateo, Alameda, Contra Costa and San Francisco counties are shown. If you live in another county, please use the Health Plan Search by Zip Code tool referred to on the previous page to determine if any other options are available to you.

PPO MEDICAL COVERAGE

CalPERS

	PERS Gold		PERS Platinum		PORAC (for dues paying police officers only)	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Annual Deductible	$1,000 ind [1] $2,000 fam [1]	$2,500 ind $5,000 fam	$500 ind $1,000 fam	$2,000 ind $4,000 fam	$300 ind $900 fam	$600 ind $1,800 fam
Routine & Specialist Office Visit	$35 [2]	40%	$20/$35	40%	$10/$35	20%
Preventive Care Services	No charge	40%	No charge	40%	No charge	No charge
Urgent Care Visit	$35	40%	$35	40%	$35	20%
Emergency Room Visit	20% + $50 copay per visit		10% + $50 copay per visit		20%	20%
Diagnostic X-Ray / Lab	20%	40%	10%	40%	20%	20%
Durable Medical Equipment	20%	40%	10%	40%	20%	20%
Inpatient Hospitalization	20%	40%	10% + $250 ded per admit	40% + $250 ded per admit	20%	20%
Outpatient Facility / Surgery Services	20%	40%	10%	40%	20%	20%
Surgery / Anesthesia	20%	40%	10%	40%	20%	20%
Occupational / Physical / Speech Therapy	20%	20% occupational 40% all others	10%	10% occupational 40% all others	$15 occ/phy 20% all others	20%
Acupuncture / Chiropractic	$15 copay 20 combined visits	40%	$15 copay 20 combined visit	40%	$15 copay Chiro up to 20 visits	20%
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
Max Calendar Year Coinsurance (excluding pharmacy)	$3,000 ind $6,000 fam	NA	$2,000 ind $4,000 fam	NA	$2,000 ind $4,000 fam	NA
Max Calendar Year Out-of-Pocket (excluding pharmacy)	$6,700 ind $13,400 fam	NA	$6,700 ind $13,400 fam	NA	$2,000 ind $4,000 fam	NA
Prescription Drugs (Generic / Preferred / Non-Preferred)						
Retail Pharmacy** (not to exceed 30-day supply)	$5 / $20 / $50		$5 / $20 / $50		$10 / $25 / $45	
Mail Order Pharmacy** (not to exceed 90-day supply)	$10 / $40 / $100		$10 / $40 / $100		$20/$40/$75	NA

Above is a snapshot summary. Refer to the plan's Evidence of Coverage (EOC) for the full summary of coverage information.

[1] Incentives available to reduce individual deductible for inpatient care (max. $500) 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] Reduced to $10 if enrolled with personal doctor.

* Out-of-network services are based on a strictly limited schedule of allowances. Members must pay charges in excess of those scheduled amounts.

** Review your plan to ensure if Retail Pharmacy Maintenance Medications require a Home Delivery Opt-Out form to be completed to continue to have prescriptions filled at retail. Plans that do not require Home Delivery for Maintenance Medications may be subject to a higher copay after the 2nd fill.