

CaIPERS 2026 Health Plan Highlights Region 3 Counties Los Angeles, Riverside & San Bernardino	CaIPERS HMO PLAN OPTIONS							
	Kaiser	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Blue Shield TRIO HMO	Health Net	United Healthcare SignatureValue Alliance	United Healthcare SignatureValue Harmony
Office Visit/Specialist	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Preventative Services/Basic Lab/X-ray	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
Prescription Drugs								
Generic/Brand/Non-Formulary								
Retail Pharmacy 30-day supply	\$5 / \$20	\$5 / \$20 / \$50	\$5 / \$20 / \$50	\$5 / \$20 / \$50	\$5 / \$20 / \$50	\$5 / \$20 / \$50	\$5 / \$20 / \$50	\$5 / \$20 / \$50
Retail Maint. Meds after 2nd refill	N/A	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100
Mail Order 90-day supply	\$ 10 / \$40	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100	\$10 / \$40 / \$100
Durable Medical Equipment	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Co-Payment	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Waived if admitted	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Approved Facility/Surgery Services	\$15	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Chiropractic Care (combined with Acupuncture)	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit
	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.
Occupational/Physical/Speech Therapy								
Inpatient Care	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
Outpatient Care	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Max Co-Payment Liability - Single	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500
Family	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000
*Max Out-of-Pocket - Single	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500
Family	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000
Calendar Year Deductible - Single	N/A	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	N/A
Monthly Premium over 12 Months								
Single	\$0.00	\$0.00	\$159.48	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Plus 1	\$0.00	\$0.00	\$318.96	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Family	\$0.00	\$0.00	\$414.65	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Monthly Premium over 10 Months								
Single	\$0.00	\$0.00	\$191.38	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Plus 1	\$0.00	\$0.00	\$382.75	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Family	\$0.00	\$0.00	\$497.58	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

* Separate Prescription Drug Maximum

CalPERS 2026 Health Plan Highlights	CalPERS Blue Shield of CA PPO Plan Options			
	PERS Gold		PERS Platinum	
Region 3 Counties Los Angeles, Riverside & San Bernardino	PPO	Out of Network	PPO	Out of Network
Office Visit/Specialist	\$10 / \$35	40%	\$20 / \$35	40%
Preventative Services/Basic Lab/X-ray	No Charge	40%	No Charge	40%
Prescription Drugs				
Generic/Brand/Non-Formulary				
Retail Pharmacy 30-day supply	\$5 / \$20 / \$50		\$5 / \$20 / \$50	Not Covered
Retail Maint. Meds after 2nd refill	\$10 / \$40 / \$100		\$10 / \$40 / \$100	Not Covered
Mail Order 90-day supply	\$10 / \$40 / \$100		\$10 / \$40 / \$100	Not Covered
Durable Medical Equipment	20%	40%	10%	40%
Urgent Care Visits	\$35	40%	\$35	40%
Emergency Room Deductible	20%	40%	10%	40%
Co-Payment	\$50		\$50	
Waived if admitted	Yes	Yes	Yes	Yes
Hospital	N/A		\$250	
Inpatient Care	20% or 30%	40%	10%	40%
Outpatient Approved Facility/Surgery Services	20% or 30%	40%	10%	40%
Chiropractic Care (combined with Acupuncture)	\$15/visit	40%	\$15/visit	40%
	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.	20 visits/cal. yr.
Occupational/Physical/Speech Therapy				
Inpatient Care	No charge		No Charge	
Outpatient Care	20%	40%	10%	40%
		Occ. therapy 20%		Occ. Therapy 10%
Max Co-Payment Liability - Single	\$3,000	N/A	\$2,000	N/A
Family	\$6,000	N/A	\$4,000	N/A
*Max Out-of-Pocket - Single	\$8,150	N/A	\$8,150	N/A
Family	\$16,300	N/A	\$16,300	N/A
Calendar Year Deductible - Single	\$1,000	\$2,500	\$500	\$2,000
Family	\$2,000	\$5,000	\$1,000	\$4,000
Monthly Premium over 12 Months				
Single	\$0.00		\$462.76	
Plus 1	\$0.00		\$925.52	
Family	\$0.00		\$1,203.18	
Monthly Premium over 10 Months				
Single	\$0.00		\$555.31	
Plus 1	\$0.00		\$1,110.62	
Family	\$0.00		\$1,443.82	

* Separate Prescription Drug Maximum