

CalPERS 2020 Plan Highlights Region 2 Counties Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura	CalPERS HMO PLAN OPTIONS							
	Kaiser	Anthem HMO Select	Anthem HMO Traditional	Blue Shield Access+	Health Net Salud y Mas	Health Net SmartCare	Sharp Health Plan	United Healthcare
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 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	\$ -	\$ 8.80	\$ 289.71	\$ 264.63	\$ -	\$ 74.02	\$ -	\$ 26.36
Plus 1	\$ -	\$ 17.60	\$ 579.42	\$ 529.26	\$ -	\$ 148.04	\$ -	\$ 52.72
Family	\$ -	\$ 22.88	\$ 753.25	\$ 688.04	\$ -	\$ 192.46	\$ -	\$ 68.54
Monthly Premium over 10 Months								
Single	\$ -	\$ 10.56	\$ 347.65	\$ 317.56	\$ -	\$ 88.82	\$ -	\$ 31.63
Plus 1	\$ -	\$ 21.12	\$ 695.30	\$ 635.11	\$ -	\$ 177.65	\$ -	\$ 63.26
Family	\$ -	\$ 27.46	\$ 903.90	\$ 825.65	\$ -	\$ 230.95	\$ -	\$ 82.25

*Separate Prescription Drug Max

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	PERS Choice		PERS Select		PERS Care	
	PPO	Non PPO	PPO	Non PPO	PPO	Non PPO
Office Visit/Specialist	\$20 / \$35	40%	\$20	40%	\$20 / \$35	40%
Preventative Services/Basic Lab/X-ray	No Charge	40%	No Charge	40%	No Charge	40%
Prescription Drugs						
Generic/Brand/Non-Formulary						
Retail Pharmacy 30-day supply	\$5 / \$20 / \$50	Not Covered	\$5 / \$20 / \$50	Not Covered	\$5 / \$20 / \$50	Not Covered
Retail Maint. Meds after 2nd refill	\$10 / \$40 / \$100	Not Covered	\$10 / \$40 / \$100	Not Covered	\$10 / \$40 / \$100	Not Covered
Mail Order 90-day supply	\$10 / \$40 / \$100	Not Covered	\$10 / \$40 / \$100	Not Covered	\$10 / \$40 / \$100	Not Covered
Durable Medical Equipment	20%	40%	20%	40%	10%	40%
Urgent Care Visits	\$35	40%	\$20	40%	\$35	40%
Emergency Room Deductible	20%	40%	20%	40%	10%	40%
Co-Payment	\$50		\$50		\$50	
Waived if admitted	Yes	Yes	Yes	Yes	Yes	Yes
Hospital	N/A		N/A		\$250	
Inpatient Care	20%	40%	20% or 30%	40%	10%	40%
Outpatient Facility/Surgery Services	20%	40%	20% or 30%	40%	10%	40%
Chiropractic Care (combined with Acupuncture)	\$15/visit	40%	\$15/visit	40%	\$15/visit	60%
	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 charge		No charge		No Charge	
Outpatient Care	20%	40%	20%	40%	10%	40%
		Occ. therapy 20%		Occ. therapy 20%		Occ. Therapy 10%
Max Co-Payment Liability - Single	\$3,000	N/A	\$3,000	N/A	\$2,000	N/A
Family	\$6,000	N/A	\$6,000	N/A	\$4,000	N/A
*Max Out-of-Pocket - Single	\$5,150	N/A	\$5,150	N/A	\$5,150	N/A
Family	\$10,300	N/A	\$10,300	N/A	\$10,300	N/A
Calendar Year Deductible - Single	\$500	Non-transferrable	\$500	Non-transferable	\$500	Non-transferable
Family	\$1,000	between plans	\$1,000	between plans	\$1,000	between plans
Monthly Premium over 12 Months						
Single	\$91.04		\$ -		\$341.42	
Plus 1	\$182.08		\$ -		\$682.84	
Family	\$236.71		\$ -		\$887.70	
Monthly Premium over 10 Months						
Single	\$109.25		\$ -		\$409.70	
Plus 1	\$218.50		\$ -		\$819.41	
Family	\$284.05		\$ -		\$1,065.24	

*Separate Prescription Drug Max