CalPERS 2020 Plan Highlights Region 3 Counties Los Angeles, Riverside & San Bernardino	CalPERS HMO PLAN OPTIONS						
	Kaiser	Anthem HMO Select	Anthem HMO Traditional	Blue Shield Access+	Health Net Salud y Mas	Health Net SmartCare	United Healthcare
Office Visit/Specialist	$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
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
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
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
Durable Medical Equipment	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
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Co-Payment	$50	$50	$50	$50	$50	$50	$50
Waived if admitted	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hospital	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
Outpatient Facility/Surgery Services	$15	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
	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
Outpatient Care	$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
Family	$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
Family	$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
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Monthly Premium over 12 Months							
Single	$ -	$ -	$ 238.24	$ 148.78	$ -	$ -	$ 3.92
Plus 1	$ -	$ -	$ 476.48	$ 297.56	$ -	$ -	$ 7.84
Family	$ -	$ -	$ 619.43	$ 386.83	$ -	$ -	$ 10.20
Monthly Premium over 10 Months							
Single	$ -	$ -	$ 285.89	$ 178.54	$ -	$ -	$ 4.70
Plus 1	$ -	$ -	$ 571.78	$ 357.07	$ -	$ -	$ 9.41
Family	$ -	$ -	$ 743.32	$ 464.20	$ -	$ -	$ 12.24

*Separate Prescription Drug Max

CalPERS 2020 Plan Highlights	CalPERS Anthem Blue Cross PPO Plan Options					
	PERS Choice		PERS Select		PERSCare	
Region 3 Counties	PPO	Non PPO	PPO	Non PPO	PPO	Non PPO
Los Angeles, Riverside & San Bernardino						
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		$5 / $20 / $50	Not Covered
Retail Maint. Meds after 2nd refill	$10 / $40 / $100	Not Covered	$10 / $40 / $100		$10 / $40 / $100	Not Covered
Mail Order 90-day supply	$10 / $40 / $100	Not Covered	$10 / $40 / $100		$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	$45.90		$ -		$266.73	
Plus 1	$91.80		$ -		$533.46	
Family	$119.34		$ -		$693.50	
Monthly Premium over 10 Months						
Single	$55.08		$ -		$320.08	
Plus 1	$110.16		$ -		$640.15	
Family	$143.21		$ -		$832.20	

*Separate Prescription Drug Max