No co-pay	CalPERS			CalPE	RS HMO PLAN OP	TIONS		
Stock   Stoc	Region 3 Counties	Kaiser						
No co-pay	Los Angeles, Riverside & San Bernardino							
No co-pay								
Reservicing   Servicing   Se	Office Visit/Specialist	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Reservicing   Servicing   Se								
Genetic Pland/Non-Formulary	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
Genetic Pland/Non-Formulary								
Retail Pharmacy 30-day supply								
Retail Maint. Macks after Zord retfill								
Mail Order 90-day supply								
No co-pay								
State   Stat	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
State   Stat	5 11 14 15 15 1							
Single   S	Durable Medical Equipment	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
Single   S	Lirgant Cara Visita	¢4 <i>E</i>	¢4E	C4F	¢15	Ф4 <i>Е</i>	¢4.5	<b>C4 C</b>
Section   Sect	orgeni Care visits	\$15	\$15	φ15	\$15	\$15	\$15	\$15
Section   Sect	Emergency Poom Deductible	NI/A	NI/A	NI/A	N/A	NI/A	N/A	NI/A
Vest								
Ni/A					·			
Inpatient Care	vvalved ii dariitted	100	103	103	100	103	103	103
Inpatient Care	Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cultratient Facility/Surgery Services	Inpatient Care		No Charge					No Charge
Chiropractic Care (combined with Acupuncture)   \$15/visit   \$15/	Outpatient Facility/Surgery Services				•			
20 visits/cal. yr.   20 visi			, and the second			Ü		Ĭ .
Decupational/Physical/Speech Therapy	Chiropractic Care (combined with Acupuncture)	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit
Inpatient Care		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.
Inpatient Care								
Outpatient Care \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15	Occupational/Physical/Speech Therapy							
Max Co-Payment Liability - Single \$1,500 \$1,500 \$1,500 \$1,500 \$1,500 \$1,500 \$1,500 \$3,000 \$3,	•	No co-pay		·				
Samily	Outpatient Care	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Samily								
Max Out-of-Pocket - Single \$1,500 \$1,	, , ,							
Family \$3,000 \$3	Family	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000
Family \$3,000 \$3	*** 0	A4 =00	04.500	A4 =00	<b>A</b> 4 =00	04.500	04.500	A - = 0.0
Calendar Year Deductible - Single								
Family N/A N/A<	ramily	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000
Family N/A N/A<	Calendar Vear Deductible - Single	N/Δ	N/A	N/A	N/Δ	N/Δ	N/A	N/A
Monthly Premium over 12 Months \$ - \$ - \$ 238.24 \$ 148.78 \$ - \$ - \$ 3.93   Plus 1 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 7.84   Family \$ - \$ - \$ 619.43 \$ 386.83 \$ - \$ - \$ 10.20   Monthly Premium over 10 Months \$ - \$	Ÿ							
Single \$ - \$ - \$ 238.24 \$ 148.78 \$ - \$ 3.93   Plus 1 \$ - \$ - \$ 476.48 \$ 297.56 \$ - \$ 7.86   Family \$ - \$ - \$ 619.43 \$ 386.83 \$ - \$ - \$ 10.20   Monthly Premium over 10 Months - \$	,	14/71	14/71	14/74	14/7	14/71	14/71	14/71
Plus 1 \$ - \$ - \$ 476.48 \$ 297.56 \$ - \$ 7.86   Family \$ - \$ - \$ 619.43 \$ 386.83 \$ - \$ - \$ 10.20   Monthly Premium over 10 Months Single \$ - \$		\$ -	\$ -	\$ 238.24	\$ 148.78	\$ -	\$ -	\$ 3.92
Family \$ - \$ - \$ 619.43 \$ 386.83 \$ - \$ 10.20   Monthly Premium over 10 Months Single \$ - \$ - \$ 178.54 \$ - \$ - \$ 4.70   Plus 1 \$ - \$ - \$ 571.78 \$ 357.07 \$ - \$ - \$ 9.4	-							
Monthly Premium over 10 Months Single Single<								
Single \$ - \$ - \$ 285.89 \$ 178.54 \$ - \$ - \$ 4.70   Plus 1 \$ - \$ - \$ 571.78 \$ 357.07 \$ - \$ - \$ 9.4	·							
Plus 1 \$ - \$ - \$ 571.78 \$ 357.07 \$ - \$ - \$ 9.4		\$ -	\$ -	\$ 285.89	\$ 178.54	\$ -	\$ -	\$ 4.70
						<u>'</u>		
	Family	\$ -					_	\$ 12.24

<sup>\*</sup>Separate Prescription Drug Max

CalPERS	CalPERS Anthem Blue Cross PPO Plan Options								
2020 Plan Highlights	PERS	S Choice	PERSCare						
Region 3 Counties	PPO	Non PPO	PPO	S Select 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		20 / \$50	\$5 / \$20 / \$50	Not Covered			
Retail Maint. Meds after 2nd refill	\$10 / \$40 / \$100	Not Covered		340 / \$100	\$10 / \$40 / \$100	Not Covered			
Mail Order 90-day supply	\$10 / \$40 / \$100	Not Covered	\$10/\$	340 / \$100	\$10 / \$40 / \$100	Not Covered			
Dunchie Medical Fauir cont	000/	400/	000/	400/	400/	400/			
Durable Medical Equipment	20%	40%	20%	40%	10%	40%			
Urgent Care Visite	\$35	40%	\$20	40%	\$35	40%			
Urgent Care Visits	φυο	40%	<b>Φ2</b> 0	40%	φοο	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.			
0 1 1/0 1 1/0 1 7									
Occupational/Physical/Speech Therapy						<u> </u>			
Inpatient Care		charge		charge		Charge			
Outpatient Care	20%	40%	20%	40%	10%	40%			
Mary Ca. Dayman and Linkillian Circula	<b>#0.000</b>	Occ. therapy 20%	<b>#0.000</b>	Occ. therapy 20%	<b>#0.000</b>	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			
*May Out of Booket Single	¢5 150	N/A	¢5 150	Ν1/Λ	¢5 150	NI/A			
*Max Out-of-Pocket - Single	\$5,150 \$10,300	N/A N/A	\$5,150 \$10,300	N/A N/A	\$5,150 \$10,300	N/A N/A			
Family	\$10,300	IN/A	\$10,300	IN/A	\$10,300	IN/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				

<sup>\*</sup>Separate Prescription Drug Max