



2008 Health Benefit Summary

A side-by-side comparison of all CalPERS health plans



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Information About Your CalPERS Health Benefits

About the Health Benefit Summary

This Health Benefit Summary booklet summarizes benefits offered by CalPERS Health Maintenance Organization (HMO), Exclusive Provider Organizations (EPO), and Preferred Provider Organization (PPO) plans. It is intended to help you choose the CalPERS health plan that best meets your needs.

This summary provides only a general overview of benefits. It does not include details of all covered expenses or exclusions and limitations. Please refer to each plan's Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. Plans mail EOCs to current members before Open Enrollment, to new members at the beginning of the year, and to CalPERS members upon request. In case of a conflict between this summary and your plan's EOC, the EOC booklet determines the benefits that will be provided. Note: Some health plans require binding arbitration to resolve disputes. Please refer to the CalPERS *Health Program Guide* for more information.

This booklet is to be used only in conjunction with the current year rate schedule. To obtain an additional copy of the rate schedule for the health plan in which you are currently enrolled, please contact CalPERS at **888 CalPERS** (or **888-225-7377**).

Understanding Health Plan Availability

In this booklet, you will find a chart that indicates which CalPERS health plans are available in each California county, as well as out-of-state (see pages 28-29).

In general, active employees and working CalPERS retirees may enroll in a health plan using either their home or work ZIP Code. (The exception to this rule applies to members enrolling in Kaiser Permanente Senior Advantage, who must use only their residential ZIP Code.) If you are using your home ZIP Code, all enrolled dependents must live in the health plan's service area. If you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not live in that service area.

If you are a retired CalPERS member, you may select any plan in your residential ZIP Code area. Retirees cannot use the address of the employer from which they retired to establish ZIP Code eligibility unless it is a non-CalPERS covered employer.

Choosing a Health Plan

When you choose a health plan, be sure to review the plan's covered and non-covered services, and the restrictions on your choice of providers. In addition to the information in this booklet, we have several other resources available to assist you in making your health plan choice, including the **Health Plan Chooser** tool and the **Health Plan Search by ZIP Code** locator tool. Both of these resources are available on the CalPERS Web site at www.calpers.ca.gov.



Benefit Design Changes for 2008

Basic HMO Plans Offer Free Preventive Care

If you are enrolled in one of CalPERS Basic HMO health plans (Blue Shield of California or Kaiser Permanente) next year, you will have no co-payment for most preventive care office visits. We hope this encourages you to take advantage of the preventive care services our health plans offer, including periodic health exams, maternity care, well baby visits, allergy testing and treatment, immunizations, hearing evaluations, and pre/post-natal care. Again, most of these services will be **free** for Basic HMO members in 2008.

New Plans Provide Additional Opportunities to Save

You might be able to save on your health care premium next year by enrolling in one of the new “high performance network” plan options – Blue Shield NetValue (HMO) and PERS Select (PPO). These plans will provide the same level of benefits and quality of care, but they will cost less than the standard Blue Shield Access+ and PERS Choice plans. NetValue will be available in 17 counties, and PERS Select in 54 counties. If you don’t live in one of these counties, perhaps you work in one. In that case, you may be able to enroll in one of these lower cost plan options based on your work Zip Code. (See “Understanding Health Plan Availability” section on page 2.)

How These Changes Could Save Money and Enhance Benefits

To illustrate the value of these benefit design changes, let’s use the example of a State member who currently has health coverage for herself and her family (husband, 4-year old child, and a baby on the way) through Blue Shield.

If this member transfers from the standard Blue Shield HMO family plan to Blue Shield NetValue (high performance network), she will save more than \$1,500 in premiums in 2008. She can use this savings to pay for additional health care services for her family, such as co-payments for 20 doctor’s office visits for non-preventive care, 12 retail generic drug prescriptions, 12 retail brand prescriptions, 4 mail-order brand prescriptions, 4 mail-order non-formulary prescriptions, 12 urgent care visits, and 3 emergency room visits (without being admitted) – and still keep an extra \$265 in her pocket.

On top of that, she and her family members will receive **free** preventive care services, as outlined above.

Other Co-payment Changes

In addition to waiving the co-payment for most preventive care office visits and adding two new plan options, here are the other changes that will be in place for our **Basic HMO** health plans in 2008:

- Non-preventive care office visit co-pays increased by \$5 (from \$10 to \$15)
- Co-pays for urgent care standardized to \$15 (currently \$25 for Blue Shield, and \$10 for Kaiser)
- Annual out-of-pocket maximum created for Blue Shield – \$1,500 for an individual and \$3,000 for a family, excluding pharmacy (Kaiser already has these maximums in effect.)



CalPERS Basic Health Care Plans Benefits and Co-pay and/or Benefit Limits

| Benefits | HMO Basic Plans | | | | |
|---|--|-------------------------|-----------------|--------------------------|------------------------|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Calendar Year Deductible | | | | | |
| Individual | ←————— N/A —————→ | | | | |
| Family | ←————— N/A —————→ | | | | |
| Maximum Calendar Year Co-pay (excluding pharmacy) | | | | | |
| Individual | ←————— \$1,500 (see EOC for other items not counted toward co-pay max limit) —————→ | | | | |
| Family | \$3,000 | \$3,000 | \$3,000 | \$3,000 | \$4,500 |
| ←————— (see EOC for other items not counted toward co-pay max limit) —————→ | | | | | |
| Lifetime Maximum Benefit | | | | | |
| ←————— N/A —————→ | | | | | |
| Hospital Admission Deductible | | | | | |
| Per Admission | ←————— N/A —————→ | | | | |
| Hospital | | | | | |
| Inpatient | ←————— No Charge —————→ | | | | \$100/admission |
| Outpatient Facility Services | \$15 | ←————— No Charge —————→ | | | |
| Outpatient Surgery | \$15 | No Charge | No Charge | No Charge | \$50 |
| Emergency Room Deductible | | | | | |
| ←————— N/A —————→ | | | | | |
| Emergency Services | | | | | |
| Emergency | ←————— \$50 (co-pay waived if admitted as an inpatient or for observation as an outpatient) —————→ | | | | \$75 |
| Non-emergency | | | | | N/A |
| Ambulance Services | | | | | |
| ←————— No Charge —————→ | | | | | |

Note: All footnotes are located at the end of chart.

| PPO Basic Plans | | | | | | | | | | |
|------------------------|---------|---|---------|----------|---------|--|--|---|------------------|--|
| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | | |
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | |
| ← | | \$500 (not transferable between plans) | | → | | N/A | | \$300 | \$600 | |
| ← | | \$1,000 (not transferable between plans) | | → | | N/A | | \$900 | \$1,800 | |
| \$3,000 | N/A | \$3,000 | N/A | \$2,000 | N/A | \$2,000 | N/A | \$3,000 | | |
| \$6,000 | | \$6,000 | | \$4,000 | | \$4,000 | | \$6,000 | | |
| \$2,000,000/individual | | \$2,000,000/individual | | N/A | | \$2,000,000 | | N/A | | |
| N/A | | N/A | | \$250 | | N/A | | N/A | | |
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | Varies (see EOC) | 10% | 10% ³ | |
| | | | | | | | | 40% | | |
| | | | | | | | | 40% | | |
| ← | | \$50 (applies to hospital emergency room charges only; deductible waived if admitted as an inpatient or for observation as an outpatient) | | → | | ← | | N/A | | |
| 20% | | 20% | | 10% | | \$50 + 10% (co-pay reduced to \$25 if admitted on an inpatient basis) | \$50 + 10% (co-pay reduced to \$25 if admitted on an inpatient basis) | 10% | | |
| 20% | 40% | 20% | 40% | 10% | 40% | | \$50 + 40% (co-pay reduced to \$25 if admitted on an inpatient basis) | 50% (for non-emergency services provided by hospital emergency room) | | |
| ← | | → | | 20% | | → | | → | | |

| Benefits | HMO Basic Plans | | | | |
|---|------------------------------------|-------------------------|-----------------|--------------------------|------------------------|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Physician Services | | | | | |
| Office Visits <i>(more than one co-pay may apply during an office visit if multiple services are provided)</i> | ← | | \$15 | | → |
| Inpatient Hospital Visits | ← | | No Charge | | → |
| Outpatient Hospital Visits | \$15 (outpatient surgery) | ← | No Charge | | → |
| Urgent Care Visits | ← | | \$15 | | \$25 |
| Periodic Health Exam/Preventive Care | No Charge (for physical exam) | ← | No Charge | | \$15 |
| Gynecological Exam | \$15 (No Charge for well woman) | ← | No Charge | | \$15 |
| Immunization/Inoculation | ← | | No Charge | | → |
| Well Baby Care | ← | | No Charge | | \$15 |
| Pregnancy & Maternity Care <i>(includes pre-natal and post-natal care visits)</i> | ← | | No Charge | | \$15 |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | |
|--|---------|--|---------|--|---------|---|---------|--|---|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |
| \$20 ¹ | 40% | \$20 ² | 40% | \$20 ² | 40% | \$15 | 40% | \$20 (deductible does not apply) | 10% ³ |
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% | 40% | 10% | 10% ³ |
| \$20 ¹ | 40% | \$20 ² | 40% | \$20 ² | 40% | 10% | 40% | 10% | 10% ³ |
| \$20 | 40% | \$20 | 40% | \$20 | 40% | \$15 | 40% | \$20 (deductible does not apply) | 10% ³ |
| No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ¹ | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (\$300/year max) | | No Charge (up to PPO and Non-PPO combined max of \$500/year for age 7 and over) | No Charge ³ (up to PPO and Non-PPO combined max of \$500/year for age 7 and over) |
| No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ¹ | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | 10% | 40% | No Charge (up to PPO and Non-PPO combined max \$500/year) | No Charge ³ (up to PPO and Non-PPO combined max \$500/year) |
| No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ¹ | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (\$300/year max) | | No Charge (included in well baby/well child) | |
| No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ¹ | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (not subject to the calendar year deductible when services are obtained from a preferred provider) ² | 40% | No Charge (for children under age 7) | | No Charge (up to PPO and Non-PPO combined max \$500/year for age 7 and over) | No Charge ³ (up to PPO and Non-PPO combined max \$500/year for age 7 and over) |
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% | 40% | 10% | 10% ³ |

| Benefits | HMO Basic Plans | | | | | |
|---|---|-------------------------|---|--------------------------|--|---|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan | |
| Physician Services (continued) | | | | | | |
| Allergy Testing | \$15 | ← | No Charge | → | \$15 | |
| Allergy Treatment | No Charge (for allergy injections) | ← | No Charge | → | \$15 | |
| Vision Exam (Refraction) | \$15 | ← | No Charge (varies by plan for age 18 and over and may be limited to one visit/calendar year) | → | \$15 (varies by plan for age 18 and over and may be limited to one visit/calendar year) | |
| Hearing Exam/Screening | ← | No Charge | | | → | \$15 |
| Surgery/Anesthesia | No Charge for inpatient; \$15 for outpatient | ← | No Charge | | → | |
| Diagnostic X-Ray/Lab | | | | | | |
| | No Charge (some procedures may require a co-pay) | ← | No Charge | | → | |
| Prescription Drugs | | | | | | |
| Deductible | ← | N/A | | | → | Brand Formulary: \$50 (not to exceed \$150/family/calendar year) |
| Retail Pharmacy | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | ← | Generic: \$5 Brand Formulary: \$15 Non-Formulary: \$45 (not to exceed 30-day supply) | → | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$50 (not to exceed 30-day supply) | |
| Medical Necessity/Partial Waiver | ← | N/A | | | → | |
| Retail Pharmacy Maintenance Medications Filled after 2nd Fill (a medication taken longer than 60 days) | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | ← | Generic: \$5 Brand Formulary: \$15 Non-Formulary: \$45 (not to exceed 30-day supply) | → | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$50 (not to exceed 30-day supply) | |
| Medical Necessity/Partial Waiver | ← | N/A | | | → | |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | |
|-------------|---------|-------------|---------|----------|---------|-----------------------|---------|------------------------|---------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |

| | | | | | | | | | |
|------------------|-----|------------------|-----|------------------|-----|----------------------------------|----------------------------------|---|--|
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% | 40% | 10% | 10% ³ |
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% | 40% | 10% | 10% ³ |
| ← Not Covered → | | | | | | | | | |
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% (\$200 max/ 36 months) | 40% (\$200 max/ 36 months) | 20% (deductible does not apply; \$50/ exam max with hearing aid purchase) | 20% ³ (deductible does not apply; \$50/ exam max with hearing aid purchase) |
| 20% ¹ | 40% | 20% ² | 40% | 10% ² | 40% | 10% | 40% | 10% | 10% ³ |

| | | | | | | | | | |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------|
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | 10% | 10% ³ |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|------------------|

| | | | | | | | | | |
|---------|--|---|--|--|--|---|--|--|--|
| ← N/A → | | | | | | | | | |
| | | Generic: \$5 Preferred: \$15 Non-Preferred: \$45 | | | | Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$25 | | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45 | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: Not Covered (see EOC) |
| | | \$30 | | | | N/A | | N/A | |
| | | Generic: \$10 Preferred: \$25 Non-Preferred: \$75 | | | | Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$50 | | N/A | |
| | | \$45 | | | | N/A | | N/A | |

| Benefits | HMO Basic Plans | | | | |
|---|--|---|-----------------|--------------------------|---|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Prescription Drugs (continued) | | | | | |
| Mail Order Pharmacy Program | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$75 (not to exceed 90-day supply) | | | Generic: \$20 Brand Formulary: \$50 Non-Formulary: \$100 (not to exceed 90-day supply) |
| Medical Necessity/Partial Waiver | N/A | | | | |
| Maximum co-payment per person per calendar year | N/A | \$1,000 | | | N/A |
| Durable Medical Equipment | | | | | |
| No Charge | | | | | |
| Infertility Testing/Treatment | | | | | |
| 50% of covered charges (varies – see EOC for benefits and exclusions) | | | | | |
| Substance Abuse Treatment | | | | | |
| Inpatient | No Charge | | | | \$100/admission (limited to acute medical detoxification only) |
| Outpatient | \$15 individual therapy \$5 group therapy (evaluation, crisis intervention, and treatment for conditions subject to significant improvement through short-term therapy) | \$15 (up to 20 visits/calendar year; evaluation, crisis intervention, and treatment for conditions subject to significant improvement through short-term therapy) | | | \$10 per visit (up to 20 visits/calendar year; evaluation, crisis intervention, and treatment for conditions subject to significant improvement through short-term therapy) |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | |
|-------------|---------|-------------|---------|----------|---------|-----------------------|---------|------------------------|---------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |

| | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|-----|
| | | Generic: \$10 Preferred: \$25 Non-Preferred: \$75 | | | | Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$50 | | Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75 (see EOC for specialty pharmacy fees) | | N/A |
| | | \$45 | | | | N/A | | | | N/A |
| | | \$1,000 | | | | N/A | | | | N/A |

| | | | | | | | | | |
|-----|--|-----|-----|---|-----|-----|-----|-----|------------------|
| 20% | 40% (\$3,000 calendar year max applies) | 20% | 40% | 10% (pre-certification required for durable medical equipment priced at \$1,000 or more) | 40% | 10% | 40% | 20% | 20% ³ |
|-----|--|-----|-----|---|-----|-----|-----|-----|------------------|

| | | | | | | | | | |
|--|--|-------------|--|--|--|--|--|---|--|
| | | Not Covered | | | | | | 50% (up to PPO and Non-PPO combined lifetime max of \$5,000) | |
|--|--|-------------|--|--|--|--|--|---|--|

| | | | | | | | | | |
|-----|---|-----|-----|---|-----|---|--|--|--|
| 20% | 40% (up to 20 days/calendar year; \$12,000 lifetime max for any combination of inpatient and outpatient benefits) | 20% | 40% | 10% (up to 30 days/calendar year; \$12,000 lifetime max for any combination of inpatient and outpatient benefits; \$250 hospital admission deductible applies) | 40% | \$15,000 max/year; \$30,000 lifetime max | | \$150/course of treatment + 20% of remaining covered expense (with authorization); \$300/course of treatment + 50% of remaining covered expense (without authorization) | \$500 per course of treatment + 50% of remaining covered expense |
| 20% | 40% (up to 24 visits/calendar year; \$12,000 lifetime max for any combination of inpatient and outpatient benefits) | 20% | 40% | 10% (up to 30 visits/calendar year for any combination of inpatient and outpatient benefits) | 40% | | | 20% of covered expense (with authorization); 50% of covered expense (w/o authorization) | 50% of covered expense |

| Benefits | HMO Basic Plans | | | | |
|--|---|--|-----------------|--------------------------|---|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Mental Health | | | | | |
| Inpatient | ← No Charge → | | | | \$100/admission |
| Outpatient <i>(for severe mental illness of a child or adult or emotional disturbance of a child)</i> | \$15 individual therapy; \$7 group therapy | ← \$15 → | | | |
| Outpatient <i>(evaluation, crisis intervention and treatment for other mental health conditions)</i> | \$15 individual therapy (up to 20 visits); \$7 group therapy (up to 20 visits/calendar year) | ← \$20 per visit (up to 20 visits/calendar year) → | | | |
| Home Health Services (pre-certification required; custodial care not covered) | | | | | |
| | ← No Charge → | | | | \$10 per visit (up to 100 visits/calendar year) |
| Skilled Nursing Care | | | | | |
| Inpatient <i>(hospital or skilled nursing facility)</i> | No Charge (up to 100 days/benefit period) | ← No Charge (up to 100 days/calendar year) → | | | No Charge (up to 100 days/year) |
| Outpatient <i>(office and home visits)</i> | ← Not Covered (medically necessary services provided in licensed skilled nursing facility only; custodial care not covered) → | | | | |
| Occupational Therapy | | | | | |
| Inpatient <i>(hospital or skilled nursing facility)</i> | ← No Charge → | | | | |
| Outpatient <i>(office and home visits)</i> | ← \$15 → | | | No Charge | |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | |
|-------------|---------|-------------|---------|----------|---------|-----------------------|---------|------------------------|---------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |

| | | | | | | | | |
|-------|--------------------------------------|-----|-----|---|-----|---------|--|-----|
| ← 20% | 40% (up to 20 days/calendar year) | 20% | 40% | 10% (\$250 deductible/admission; up to 30 days/calendar year) | 40% | See EOC | 20% w/ authorization; 50% w/o authorization | 50% |
| 20% | 40% | 20% | 40% | 10% | 40% | | | |
| ← 20% | 40% (up to 24 days/calendar year) | 20% | 40% | 10% (up to 30 days/calendar year) | 40% | | | |

| | | | | | | | | |
|-------|--------------------------------------|-----|-----|---|-----|---|-----|---|
| ← 20% | 40% (up to \$6,000/calendar year) | 20% | 40% | 10% (up to 100 visits/calendar year) | 40% | 10% (up to 90 visits/period of disability) | 40% | 10% (100 visits max/year; combined benefit for PPO/Non-PPO) |
|-------|--------------------------------------|-----|-----|---|-----|---|-----|---|

| | | | | | | | | |
|--|---|--|---|---|---|---|-----|--|
| 20% first 10 days; 30% next 90 days (pre-certification required; up to 100 days/ calendar year) | 40% (pre-certification required; up to 100 days/ calendar year) | 20% first 10 days; 30% next 90 days (pre-certification required; up to 100 days/ calendar year) | 40% (pre-certification required; up to 100 days/ calendar year) | 10% first 10 days; 20% next 170 days (pre-certification required; up to 180 days/ calendar year) | 40% first 10 days; 40% next 170 days (pre-certification required; up to 180 days/ calendar year) | 10% (up to 100 days of confinement) | 40% | 10% (up to 100 days/year combined PPO/Non-PPO benefit for inpatient skilled nursing facility) |
| ← | Not Covered (medically necessary services received as inpatient in a skilled nursing facility only) | | | → | | 10% (up to 100 days of confinement; combined benefit for inpatient/outpatient) | 40% | N/A |

| | | | | | | | | | |
|-------|---|-----|-----|-----|-----|--|-----|---|---|
| | | | | | | | | 10% ³ (up to \$700 total chiropractic, physical, and occupational combined) | |
| ← 20% | 20% (combined benefit max of \$3,500/calendar year for physical/occupational therapy) | 20% | 20% | 20% | 40% | 10% (pre-certification required for more than 24 visits/year) | 40% | \$20 (up to 20 visits max/year for combined chiropractic, physical, and occupational therapy); 10% on all other charges | 10% ³ (up to \$35/ visit; up to \$700 total chiropractic, physical, and occupational therapy combined) |

| Benefits | HMO Basic Plans | | | | |
|--|---|---|-----------------|--------------------------|---|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Physical Therapy | | | | | |
| Inpatient <i>(hospital or skilled nursing facility)</i> | ← No Charge → | | | | |
| Outpatient <i>(office and home visits)</i> | | \$15 | | | No Charge |
| Speech Therapy | | | | | |
| Inpatient <i>(hospital or skilled nursing facility)</i> | ← No Charge → | | | | |
| Outpatient <i>(office and home visits)</i> | | \$15 | | | No Charge |
| Hospice | | | | | |
| | ← No Charge → | | | | |
| Acupuncture | | | | | |
| | \$15 (when medically necessary and performed by a Kaiser Permanente physician) | ← Not Covered (alternate care discounts of 25% or more through mylifepath alternative care discount program) → | | | Not Covered |
| Chiropractic | | | | | |
| | \$10 (20 visits/ calendar year) | ← Not Covered (alternate care discounts of 25% or more through mylifepath alternative care discount program) → | | | \$10 for exam (up to 20 visits/ calendar year); No Charge for diagnostic services; No Charge for chiropractic appliances (up to \$50 max is covered during calendar year) |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | | PORAC Association Plan | |
|-------------|---------|-------------|---------|----------|---------|-----------------------|---------|------------------------|---------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |

| | | | | | | | | | |
|---|-----|-----|-----|-----|-----|---|-----|---|---|
| | | | | | | | | 10% | 10% ³ (up to \$700 total chiropractic, physical, and occupational therapy combined) |
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | \$20 (up to 20 visits max/year for combined chiropractic, physical, and occupational therapy; more than one co-pay may apply during an office visit if multiple services are provided) | 10% ³ (up to \$35/visit; up to \$700 total chiropractic, physical, and occupational therapy combined) |
| ← (combined benefit max of \$3,500/calendar year for physical/occupational therapy) → | | | | | | (pre-certification required for more than 24 visits/year) | | | |

| | | | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|-----|------------------|
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | 10% | 10% ³ |
| ← (\$5,000 lifetime max for any combination of inpatient and outpatient benefits) → | | | | | | 10% | 40% | 10% | 10% ³ |
| | | | | | | 10% | 40% | 10% | 10% ³ |

| | | | | | | | | | |
|-----|--|--------------------------------|--|-----|--|-------------------------------------|--|-----|--|
| 20% | | 20% (\$10,000 lifetime max) | | 10% | | No Charge (\$7,500 lifetime max) | | 10% | |
|-----|--|--------------------------------|--|-----|--|-------------------------------------|--|-----|--|

| | | | | | | | | | |
|--|-----|-----|-----|--|-----|--|-----|-----|------------------|
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | 10% | 10% ³ |
| ← (combined benefit for acupuncture/chiropractic; 15 visits/calendar year) → | | | | (combined benefit for acupuncture/chiropractic; 20 visits/calendar year) | | (20 visits/year for any combination of chiropractic or acupuncture services) | | | |

| | | | | | | | | | |
|--|-----|-----|-----|--|-----|--|-----|---|---|
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | Up to 20 visits/calendar year for combined chiropractic, physical, and occupational therapy | Up to \$700 total chiropractic, physical, and occupational therapy combined |
| ← (combined benefit for acupuncture/chiropractic; 15 visits/calendar year) → | | | | (combined benefit for acupuncture/chiropractic; 20 visits/calendar year) | | (20 visits/year for any combination of chiropractic or acupuncture services) | | | |

| Benefits | HMO Basic Plans | | | | | |
|------------------------|-------------------|---|-----------------|--------------------------|------------------------|--|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan | |
| Biofeedback | \$15 | ← | Not Covered | → | \$10 | |
| Blood & Blood Products | ← | No Charge | | | → | Included w/ inpatient hospitalization |
| Hearing Aid Services | | | | | | |
| Audiological Exam | ← | No Charge | | | → | \$10 |
| Hearing Aids | ← | \$1,000 allowance every 36 months for both ears | | | → | \$500 max/ member/ calendar year for both ears |

PPO Basic Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP <i>Association Plan</i> | | PORAC <i>Association Plan</i> | |
|-------------|---------|-------------|---------|----------|---------|------------------------------|---------|-------------------------------|---------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO |

| | | | | | | | | | |
|-----|--|-----|-----|--|-----|---|--|--|--|
| 20% | 40% | 20% | 40% | 10% | 40% | 20% | | 10% | |
| ← | (combined with mental health; up to 24 visits/calendar year) | | → | (combined with mental health; up to 30 visits/calendar year) | | (other than for mental disorders and chemical dependency) | | (if in conjunction with mental health treatment) | |

| | | | | | | | | |
|-----|-----|--|-----|--|-----|--|-----|--|
| 20% | 20% | | 20% | | 20% | | 20% | |
|-----|-----|--|-----|--|-----|--|-----|--|

| | | | | | | | | | |
|-----|-----|------------------------------------|-----|-----|-----|-------------------------------|-----|--|--|
| 20% | 40% | 20% | 40% | 10% | 40% | 10% | 40% | 20% | |
| | | | | | | (\$200 max every 36 months) | | (no deductible; up to \$50 if in conjunction with purchase of hearing aid) | |
| ← | 40% | 20% | 40% | 10% | 40% | 10% | 40% | 20% | |
| | | (\$1,000 max in a 36-month period) | | → | | (\$1,000 max every 36 months) | | (no deductible; up to one/ear; \$450 max/36 months) | |

- ¹ PERS Select utilizes the Blue Cross of California Power Select PPO Network, which is a subset of the Blue Cross of California Prudent Buyer PPO Network. Approximately 50 percent of the Blue Cross Prudent Buyer PPO Network of physicians participate in the Power Select PPO Network. By obtaining physician services through the Power Select PPO Network, you will receive the highest level of reimbursement. A PERS Select member should check to see if a physician is participating in the Power Select PPO Network before receiving services.
- ² PERS Choice and PERSCare utilize the Blue Cross of California Prudent Buyer PPO Network, which is a more comprehensive network. By obtaining services through Blue Cross of California Prudent Buyer PPO Network, you will receive the highest level of reimbursement.
- ³ Covered expense for services from Non-PPO providers is based on strictly limited schedule of allowances. Members must pay charges in excess of those scheduled amounts.

CalPERS Supplement to Medicare Health Care Plans Benefits and Co-pay and/or Benefit Limits

| Benefits | HMO Medicare Plans | | | | |
|--|--|--|-----------------|--------------------------|--------------------------------|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Calendar Year Deductible | | | | | |
| Individual | ← | | N/A | | → |
| Family | ← | | N/A | | → |
| Maximum Calendar Year Co-pay (excluding pharmacy) | | | | | |
| Individual | \$1,500 (see EOC for other items not counted toward co-pay max limit) | ← | N/A | | \$1,500 |
| Family | \$3,000 | ← | N/A | | \$4,500 (3 or more members) |
| Lifetime Maximum Benefit | | | | | |
| | ← | | N/A | | → |
| Hospital Admission Deductible | | | | | |
| Per Admission | ← | | N/A | | → |
| Hospital | | | | | |
| Inpatient | ← | No Charge | | | \$100/admission |
| Outpatient Facility Services | \$10 | ← | No Charge | | → |
| Outpatient Surgery | \$10 | ← | No Charge | | → |
| Emergency Room Deductible | | | | | |
| | ← | | N/A | | → |
| Emergency Services | | | | | |
| | ← | \$50 (waived if hospitalized or kept for observation) | | | No Charge |
| Ambulance Services | | | | | |
| | ← | No Charge | | | → |
| Hearing Exam/Screening | | | | | |
| | ← | \$10 | | | No Charge |

Note: All footnotes are located at the end of chart.

| PPO Medicare Plans | | | | | | | |
|------------------------|---------|--|---------|--|---------|---|--|
| PERS Select | | PERS Choice | | PERSCare | | CAHP Association Plan | PORAC Association Plan |
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | | |
| | | N/A (plan pays Medicare Parts A and B deductible) | | | | \$100 (applicable to major medical benefits only) | \$100 (applicable to major medical benefits only) |
| | | | | | | \$200 (applicable to major medical benefits only) | \$200 (applicable to major medical benefits only) |
| N/A | | N/A | | N/A (\$3,000 when not a benefit of Medicare) | | N/A (\$3,000 when not a benefit of Medicare) | \$15,000 calendar year stop-loss (applicable to major medical benefits only, excluding outpatient prescription drug benefits) |
| | | | | N/A | | | |
| | | N/A | | | | \$1,000,000 (applicable to major medical benefits only) | \$2,000,000/individual (applicable to major medical benefits only) |
| | | | | N/A | | | |
| No Charge ¹ | | No Charge ¹ | | No Charge ¹ (20% when not a benefit of Medicare ²) | | No Charge | No Charge (after Medicare benefits are exhausted, plan pays for an additional 365 days/benefit period) |
| | | | | N/A | | | |
| | | No Charge ¹ | | | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge |
| | | No Charge ¹ | | | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge |
| | | No Charge ^{1,2} | | | | No Charge if Medicare approved | 20% (\$50 exam in connection with hearing aid purchase) |

| Benefits | HMO Medicare Plans | | | | |
|--|---|-------------------------|--|--------------------------|--|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Surgery/Anesthesia | No Charge for inpatient; \$10 for outpatient | No Charge | | | |
| Diagnostic X-Ray/Lab | No Charge (some procedures may require a co-pay) | No Charge | | | |
| Durable Medical Equipment | No Charge | | | | |
| Physician Services | | | | | |
| Office Visits | | | \$10 | | |
| Inpatient Hospital Visits | | | No Charge | | |
| Outpatient Hospital Visits | \$10 | | No Charge | | |
| Urgent Care Visits | \$10 | | \$25 | | No Charge |
| Periodic Health Exam/Preventive Care | | | \$10 | | No Charge |
| Gynecological Exam | | | \$10 | | No Charge |
| Immunization/Inoculation | No Charge | | \$10 | | No Charge |
| Allergy Testing | \$10 | | No Charge | | \$10 |
| Allergy Treatment | \$3 (for allergy injections) | | No Charge | | \$10 |
| Vision Exam (Refraction) | | | \$10 | | |
| Prescription Drugs | | | | | |
| Deductible | N/A | | | | |
| Retail Pharmacy | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | | Generic: \$5 Brand Formulary: \$15 Non-Formulary: \$45 (not to exceed 30-day supply) | | Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$35 (not to exceed 30-day supply) |
| Medical Necessity/Partial Waiver | N/A | | | | |
| Retail Pharmacy Maintenance Medications Filled after 2nd Fill (a medication taken longer than 60 days) | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | | Generic: \$5 Brand Formulary: \$15 Non-Formulary: \$45 (not to exceed 30-day supply) | | Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$35 (not to exceed 30-day supply) |
| Medical Necessity/Partial Waiver | N/A | | | | |

PPO Medicare Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP <i>Association Plan</i> | PORAC <i>Association Plan</i> |
|-------------|---------|-------------|---------|----------|---------|---------------------------------|----------------------------------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | | |

| | | | | | | | |
|---|--|------------------------|--|---|--|-----------|-----------|
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
|---|--|------------------------|--|---|--|-----------|-----------|

| | | | | | | | |
|---|--|------------------------|--|---|--|-----------|-----------|
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
|---|--|------------------------|--|---|--|-----------|-----------|

| | | | | | | | |
|---|--|------------------------|--|---|--|-----------|---|
| ← | | No Charge ¹ | | → | | No Charge | No Charge (20% when not a benefit of Medicare) |
|---|--|------------------------|--|---|--|-----------|---|

| | | | | | | | |
|------------------------|------------------------|--|--------------------------|---|-----------|---|---|
| ← | | No Charge ¹ | | → | | \$10 | No Charge |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| ← | | No Charge ¹ | | → | | Not covered (unless Medicare approved) | Not covered (unless Medicare approved) |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| No Charge ¹ | No Charge ¹ | | No Charge ^{1,2} | | No Charge | | No Charge |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| ← | | No Charge ¹ | | → | | No Charge | No Charge |
| ← | | One exam/year up to a max of \$35 ² | | → | | Not covered | 20% (one exam/calendar year) |

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| ← | | N/A | | → | | \$50 (excluding mail order) | |
| ← | | Generic: \$5 Preferred: \$15 Non-Preferred: \$45 | | → | | Generic: \$5 Single Source: \$20 Multi Source: \$25 | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 |
| ← | | \$30 | | → | | N/A | N/A |
| ← | | Generic: \$10 Preferred: \$25 Non-Preferred: \$75 | | → | | Generic: \$10 Single Source: \$40 Multi Source: \$50 | N/A |
| ← | | \$45 | | → | | N/A | N/A |

| Benefits | HMO Medicare Plans | | | | | |
|--|---|---|---|--------------------------|--|--|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan | |
| Prescription Drugs (continued) | | | | | | |
| Mail Order Pharmacy Program | Generic: \$5 (up to 100-day supply) Brand: \$15 (up to 100-day supply [30-day supply for certain drugs]) | ← | Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$75 (not to exceed 90-day supply) | → | Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$70 (not to exceed 90-day supply) | |
| Medical Necessity/Partial Waiver | ← | N/A | | | → | |
| Maximum co-payment per person/calendar year | N/A | ← | \$1,000 | → | N/A | |
| Mental Health | | | | | | |
| Inpatient | No Charge (190 lifetime days covered by Medicare; 45 additional days/calendar year covered after exhaustion of lifetime days) | ← | No Charge | → | \$100/admission | |
| Outpatient (for severe mental illness of a child or adult or emotional disturbance of a child) | \$10 individual therapy; \$5 group therapy | ← | \$10 for initial visit to determine and diagnose the condition (exception: Access+ Specialist visits require \$30 co-payment/visit) | → | \$10 | |
| Outpatient (evaluation, crisis intervention and treatment for other mental health conditions) | \$10 individual therapy; \$5 group therapy | ← | \$20 (up to 20 visits/year) | → | \$5 (up to 20 visits/calendar year) | |
| Substance Abuse Treatment | | | | | | |
| Inpatient | ← | No Charge | | | → | \$100/admission |
| Outpatient | \$10 individual therapy; \$5 group therapy | ← | \$10 (up to 20 visits/year) | → | \$5 (up to 20 visits/calendar year) | |
| Home Health Services | | | | | | |
| | ← | No Charge | | | → | No Charge (up to 100 visits/calendar year) |
| Skilled Nursing Facility Care | | | | | | |
| | ← | No Charge (up to 100 days/benefit period) | | | → | |
| Speech Therapy | | | | | | |
| Inpatient (hospital or skilled nursing facility) | No Charge | ← | | → | | |
| Outpatient (office and home visits) | \$10 | ← | \$10 | → | No Charge | |

PPO Medicare Plans

| PERS Select | | PERS Choice | | PERSCare | | CAHP <i>Association Plan</i> | PORAC <i>Association Plan</i> |
|-------------|---------|-------------|---------|----------|---------|---------------------------------|----------------------------------|
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | | |

| | | | | | | |
|---|--|---|---|--|--|---|
| ← | | Generic: \$10 Preferred: \$25 Non-Preferred: \$75 | → | | Generic: \$10 Single Source: \$40 Multi Source: \$50 | Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75 |
| ← | | \$45 | → | | N/A | N/A |
| ← | | \$1,000 | → | | N/A | N/A |

| | | | | |
|---|---|---|---|---|
| No Charge ¹ | No Charge ¹ | No Charge ^{1,2} (if not a benefit of Medicare, 20% of the physician visit up to \$32/day) | No Charge if Medicare approved (up to \$40/visit if not Medicare approved) | No Charge (20% when not a benefit of Medicare; up to \$40/inpatient physician visit) |
| No Charge ¹ | No Charge ¹ | No Charge ^{1,2} | No Charge if Medicare approved (up to \$20/visit if not Medicare approved) | No Charge (20% when not a benefit of Medicare) |
| Excess Charges ¹ (Medicare pays 50% of the approved amount for most services) | Excess Charges ¹ (Medicare pays 50% of the approved amount for most services) | Excess Charges ^{1,2} (Medicare pays 50% of the approved amount for most services; if not a benefit of Medicare, 20%/day up to \$32/day) | No Charge if Medicare approved (up to \$20/visit if not Medicare approved) | No Charge (50% when not a benefit of Medicare; up to \$20/day) |

| | | | | | | |
|---|--|---|---|--|---|---|
| ← | | No Charge ¹ | → | | Not covered (unless Medicare approved) | Not covered (unless Medicare approved) |
| ← | | Excess Charges ¹ (Medicare pays 50% of treatment that meets certain conditions) | → | | Not covered (unless Medicare approved) | Not covered (unless Medicare approved) |

| | | | | | | |
|---|--|------------------------|---|--|---|-----------|
| ← | | No Charge ¹ | → | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge |
|---|--|------------------------|---|--|---|-----------|

| | | | | |
|------------------------|------------------------|--|---|--|
| No Charge ¹ | No Charge ¹ | No Charge ¹ (up to 100 days/benefit period in a Medicare approved facility) 20% ² (from 101 to 365 days; pre-certification required) | No Charge (20% after Medicare benefits exhausted) | No Charge (after Medicare benefits are exhausted, plan pays days 101 through 365) |
|------------------------|------------------------|--|---|--|

| | | | | |
|------------------------|------------------------|--|---|---|
| No Charge ¹ | No Charge ¹ | No Charge ^{1,2} (20% when not a benefit of Medicare, up to a lifetime max plan payment of \$5,000) | No Charge if Medicare approved (20% if not Medicare approved; \$5000 lifetime max) | No Charge (20% when not a benefit of Medicare; up to \$5,000 in an individual's lifetime for all inpatient and outpatient combined) |
|------------------------|------------------------|--|---|---|

| Benefits | HMO Medicare Plans | | | | |
|--|--|---|-----------------|--------------------------|--|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Physical Therapy | | | | | |
| Inpatient (hospital or skilled nursing facility) | No Charge | ←————— \$10 —————→ | | | No Charge |
| Outpatient (office and home visits) | \$10 | | | | |
| Occupational Therapy | | | | | |
| Inpatient (hospital or skilled nursing facility) | No Charge | ←————— \$10 —————→ | | | No Charge |
| Outpatient (office and home visits) | \$10 | | | | |
| Hospice | | | | | |
| | Covered by Medicare | ←————— No Charge —————→ | | | |
| Acupuncture | | | | | |
| | \$10 (when medically necessary and performed by a Kaiser physician) | ←————— Not Covered (alternate care discounts of 25% or more through mylifepath alternative care discount program) —————→ | | | Not Covered |
| Chiropractic | | | | | |
| | \$10/visit (up to 20 visits/ calendar year unless provided by Medicare) | ←————— \$10 —————→ | | | \$10/exam (up to 20 visits/ calendar year); No Charge for diagnostic services; No Charge for chiropractic appliances (up to \$50 max is covered during calendar year) |
| Biofeedback | | | | | |
| | \$10 | ←————— No Charge —————→ | | | |
| Blood & Blood Products | | | | | |
| | | ←————— No Charge —————→ | | | Included with inpatient hospitalization |
| Diabetes Services | | | | | |
| Glucose monitors, test strips, lancets | | ←————— No Charge (see EOC for covered equipment/services) —————→ | | | |
| Self-management training | \$10 | ←————— \$10 (diabetic education to include nutritional counseling) —————→ | | | \$10/visit |

| PPO Medicare Plans | | | | | | | |
|---|---------|--|---------|--|---------|---|---|
| PERS Select | | PERS Choice | | PERSCare | | CAHP <i>Association Plan</i> | PORAC <i>Association Plan</i> |
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | | |
| No Charge ¹ | | No Charge ¹ | | No Charge ^{1,2} (20% when not a benefit of Medicare) | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge |
| No Charge ¹ | | No Charge ¹ | | No Charge ^{1,2} | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge |
| ← | | No Charge ¹ | | → | | No Charge if Medicare approved (20% if not Medicare approved; \$7500 lifetime max) | No Charge |
| Not Covered | | Not Covered | | 20% (up to 20 visits/year) ² | | No Charge if Medicare approved (20% if not Medicare approved) | 20% (major medical benefits) |
| ← | | No Charge ¹ | | → | | No Charge if Medicare approved (20% if not Medicare approved) | No Charge (20% when not a benefit of Medicare) |
| ← | | No Charge ¹ | | → | | No Charge if Medicare approved (20% if not Medicare approved) | 50% major medical benefits (up to \$40/day inpatient and \$20/day outpatient) |
| No Charge ¹ (all but first 3 pints/ calendar year) | | No Charge ¹ (all but first 3 pints/ calendar year) | | No Charge ^{1,2} (20% of the first 3 pints when not a benefit of Medicare and unreplaced) | | No Charge (first 3 units unreplaced; 20% when not a benefit of Medicare) | No Charge (first 3 units unreplaced; 20% when not a benefit of Medicare) |
| ← | | No Charge ¹ (includes diabetes self management, training, glucose monitors, test strips, lancets, etc.) | | → | | No Charge if Medicare approved | No Charge (20% when not a benefit of Medicare) |

| Benefits | HMO Medicare Plans | | | | |
|-----------------------------|--|--|-----------------|--------------------------|----------------------------------|
| | Kaiser Permanente | Blue Shield Access+ HMO | Blue Shield EPO | Blue Shield NetValue HMO | CCPOA Association Plan |
| Hearing Aid Services | | | | | |
| Audiological Exam | \$10 | ← No Charge → | | | |
| Hearing Aids | | ← \$1000 allowance every 36 months for both ears → | | | \$500 max/ member/ calendar year |
| Vision Care | | | | | |
| Vision Exam | \$10 | ← \$10 (limited to one visit per calendar year for members aged 18 and over; no limit on members under age 18) → | | | |
| Eyeglasses | \$175 allowance every 24 months; \$150 allowance following cataract surgery | ← Not Covered (except for eyeglasses necessary after cataract surgery) → | | | |
| Contact Lens | In lieu of eyeglasses: \$175 allowance every 24 months; \$150 allowance following cataract surgery | ← Not Covered → | | | |

| PPO Medicare Plans | | | | | | | |
|--------------------|---------|-------------|---------|----------|---------|---------------------------------|----------------------------------|
| PERS Select | | PERS Choice | | PERSCare | | CAHP <i>Association Plan</i> | PORAC <i>Association Plan</i> |
| PPO | Non-PPO | PPO | Non-PPO | PPO | Non-PPO | | |

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| ← | | 20% ² | | → | | 10% if not Medicare approved (\$200 maximum/36 months) | 20% (up to \$50/exam in connection with hearing aid purchase) |
| ← | | 20% ² (max payment of \$1,000 once every 36 months) | | → | | 10% if not Medicare approved (\$1000 maximum/36 months) | 20% (one/ear every 36 months up to \$450/hearing aid) |

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| ← | | One exam/calendar year ² (\$35 max allowance) | | → | | Not Covered | 20% for one exam/year |
| ← | | Two lenses/calendar year; one set of frames during a 24-month period ² Maximum Allowance: Frames: \$30 Each lens: Single Vision - \$20; Bifocal - \$35; Trifocal - \$45; Lenticular - \$50 | | → | | Not Covered (except for first pair of eyeglasses necessary after cataract surgery) | 20% (\$40 combined max for initial frames and lenses) |
| ← | | \$100 max allowance ² | | → | | Not Covered | 20% (up to \$40/year) |

¹ If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full.

² This is a benefit beyond Medicare. Refer to your Evidence of Coverage (EOC) Booklet for explanation.

Chart Legend

- Health plan covers all or part of county.
- ❖ The Blue Shield EPO Plan serves Colusa, Mendocino, and Sierra counties only. The EPO plan offers the same covered services as the Access + HMO plan, but members must seek services from Blue Shield's network of preferred providers. Members are not required to select a personal physician.



Health Plan Service Areas

To determine if the plan you are considering provides service where you live or work, find your county and follow the dots to see which plans are available. You should contact the plan before you enroll to make sure they currently cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the **Health Plan Search by ZIP Code**, available at www.calpers.ca.gov.

| County | Blue Shield Access+ HMO & EPO | Blue Shield NetValue | CAHP | CCPOA | Kaiser Permanente | PERS Choice | PERS Select | PERSCare | PORAC |
|--------------|-------------------------------|----------------------|------|-------|-------------------|-------------|-------------|----------|-------|
| Alameda | • | | • | • | • | • | | • | • |
| Alpine | | | • | | | • | • | • | • |
| Amador | | | • | | • | • | • | • | • |
| Butte | • | | • | • | | • | • | • | • |
| Calaveras | | | • | | | • | • | • | • |
| Colusa | ❖ | | • | | | • | • | • | • |
| Contra Costa | • | | • | • | • | • | • | • | • |
| Del Norte | | | • | | | • | • | • | • |
| El Dorado | • | • | • | • | • | • | • | • | • |
| Fresno | • | • | • | • | • | • | • | • | • |
| Glenn | • | | • | • | | • | • | • | • |
| Humboldt | • | | • | | | • | • | • | • |
| Imperial | • | | • | • | | • | • | • | • |
| Inyo | | | • | | | • | • | • | • |
| Kern | • | • | • | • | • | • | • | • | • |
| Kings | • | • | • | • | • | • | • | • | • |
| Lake | | | • | | | • | • | • | • |
| Lassen | | | • | | | • | • | • | • |
| Los Angeles | • | • | • | • | • | • | • | • | • |
| Madera | • | • | • | • | • | • | • | • | • |
| Marin | • | | • | • | • | • | | • | • |
| Mariposa | • | | • | • | • | • | • | • | • |
| Mendocino | ❖ | | • | | | • | • | • | • |
| Merced | • | | • | • | | • | • | • | • |
| Modoc | | | • | | | • | • | • | • |
| Mono | | | • | | | • | • | • | • |
| Monterey | | | • | | | • | • | • | • |
| Napa | | | • | • | • | • | • | • | • |
| Nevada | • | • | • | • | | • | • | • | • |
| Orange | • | • | • | • | • | • | • | • | • |

Important ...

You must live or work in the geographic service area of the health plan in order to enroll or remain enrolled in that plan.

| County | Blue Shield Access+ HMO & EPO | Blue Shield NetValue | CAHP | CCPOA | Kaiser Permanente | PERS Choice | PERS Select | PERSCare | PORAC |
|-----------------|----------------------------------|----------------------|------|-------|-------------------|-------------|-------------|----------|-------|
| Placer | • | • | • | • | • | • | | • | • |
| Plumas | | | • | | | • | • | • | • |
| Riverside | • | • | • | • | • | • | • | • | • |
| Sacramento | • | • | • | • | • | • | • | • | • |
| San Benito | | | • | | | • | • | • | • |
| San Bernardino | • | • | • | • | • | • | • | • | • |
| San Diego | • | • | • | • | • | • | • | • | • |
| San Francisco | • | | • | • | • | • | • | • | • |
| San Joaquin | • | • | • | • | • | • | • | • | • |
| San Luis Obispo | • | | • | • | | • | • | • | • |
| San Mateo | • | | • | • | • | • | • | • | • |
| Santa Barbara | • | • | • | • | | • | • | • | • |
| Santa Clara | • | | • | • | • | • | • | • | • |
| Santa Cruz | • | | • | • | | • | • | • | • |
| Shasta | | | • | | | • | • | • | • |
| Sierra | ❖ | | • | | | • | • | • | • |
| Siskiyou | | | • | | | • | • | • | • |
| Solano | • | | • | • | • | • | | • | • |
| Sonoma | • | | • | • | • | • | • | • | • |
| Stanislaus | • | | • | • | • | • | • | • | • |
| Sutter | | | • | | • | • | • | • | • |
| Tehama | | | • | | | • | • | • | • |
| Trinity | | | • | | | • | • | • | • |
| Tulare | • | | • | • | • | • | • | • | • |
| Tuolumne | | | • | | | • | • | • | • |
| Ventura | • | • | • | • | • | • | • | • | • |
| Yolo | • | • | • | • | • | • | • | • | • |
| Yuba | | | • | | • | • | • | • | • |
| Out-of-State | | | • | | • | • | | • | • |

**Kaiser Medicare
Managed Care Plan**

If you are retired and eligible for Medicare, and you are enrolled or enrolling in Kaiser Permanente’s CalPERS-sponsored Medicare Managed Care plan (called Senior Advantage in most areas), you must:

- Reside in an approved ZIP code; and
- Complete the *Senior Advantage Election* form.



If you are Medicare eligible and enrolling in the Kaiser Permanente outside of California, you must enroll in a Kaiser Medicare plan in your state. You cannot remain enrolled in the Kaiser Basic health plan.



P.O. Box 942714, Sacramento, CA 94229-2714
www.calpers.ca.gov

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