CalPERS 2024 Medical Plan Highlights Region 3 Counties Los Angeles, Riverside & San Bernardino	CalPERS HMO PLAN OPTIONS						
	Kaiser	Anthem Select HMO	Anthem Traditional HMO	Blue Shield Access+ HMO	Blue Shield TRIO HMO	United Healthcare SignatureValue Alliance	United Healthcare SignatureValue Harmony
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 Approved 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	$0.00	$0.00	$147.26	$0.00	$0.00	$0.00	$0.00
Plus 1	$0.00	$0.00	$294.52	$0.00	$0.00	$0.00	$0.00
Family	$0.00	$0.00	$382.87	$0.00	$0.00	$0.00	$0.00
Monthly Premium over 10 Months							
Single	$0.00	$0.00	$176.71	$0.00	$0.00	$0.00	$0.00
Plus 1	$0.00	$0.00	$353.42	$0.00	$0.00	$0.00	$0.00
Family	$0.00	$0.00	$459.44	$0.00	$0.00	$0.00	$0.00

*** Separate Prescription Drug Maximum**

CalPERS 2024 Medical Plan Highlights	CalPERS Anthem Blue Cross 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	$6,550	N/A	$6,550	N/A
Family	$13,100	N/A	$13,100	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		$266.06	
Plus 1	$0.00		$532.12	
Family	$0.00		$691.75	
Monthly Premium over 10 Months				
Single	$0.00		$319.27	
Plus 1	$0.00		$638.54	
Family	$0.00		$830.10	

*** Separate Prescription Drug Maximum**