



Table of Contents

HMO Basic Plans	2
PERSCare & PERS Choice Basic Plans	6
HMO Medicare Plans	
Supplement to Original Medicare and Medicare Managed Care.....	8
PERSCare & PERS Choice PPO Supplement to Medicare Plans	12
CCPOA Basic Plan (HMO)	
California Correctional Peace Officers Association	16
CCPOA Medicare Supplement Plan (HMO)	
California Correctional Peace Officers Association	20
CAHP & PORAC Basic Plans (PPOs)	
California Association of Highway Patrolmen & Peace Officers Research Association of California	22
CAHP & PORAC Medicare Supplement Plans (PPOs)	
California Association of Highway Patrolmen & Peace Officers Research Association of California	26

Important!

This booklet only provides a summary of benefits offered by CalPERS Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) plans. Please refer to each plan's Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. In case of a conflict between this summary and your plan's EOC, the EOC booklet determines the benefits that will be provided.

BENEFITS	Copay and/or Benefit Limits
HOSPITAL	
Inpatient	No charge
Outpatient	No charge
PHYSICIAN SERVICES	
Office Visits <i>More than one copay may apply during an office visit if multiple services are provided.</i>	\$10/visit
Gynecological Exam	\$10/visit
Periodic Health Exam	\$10/visit
Well-Baby Care	\$10/visit
Allergy Testing/Treatment	\$10/visit
Immunization/Inoculation	\$10/immunization
Vision Exam (Refraction) <i>For age 17 and under. Varies by plan for age 18 and over and limited to one visit per calendar year.</i>	\$10/visit
Hearing Exam/Screening	\$10/visit
Inpatient Hospital Visits	No charge
Surgery/Anesthesia	No charge
PRESCRIPTION DRUGS	
Blue Shield and Western Health Advantage Retail Pharmacy (up to 30-day supply)	\$5/generic \$15/formulary brand name \$45/non-formulary (<i>\$30 if medical necessity approved</i>)
Mail Order Program (up to 90-day supply) <i>\$1,000 maximum copayment per person per calendar year.</i>	\$10/generic \$25/formulary brand name \$75/non-formulary (<i>\$45 if medical necessity approved</i>)
Kaiser Permanente <i>Provides up to 100-day supply (or a 30-day supply for certain drugs) through either its pharmacies or mail order program.</i>	\$5/generic \$15/brand name

BENEFITS	Copay and/or Benefit Limits
DIAGNOSTIC X-RAY/LAB	
Outpatient Services	No charge
DURABLE MEDICAL EQUIPMENT	
	No charge
INFERTILITY TESTING/TREATMENT	
<i>Professional, hospital, ambulatory surgery center, ancillary services and drugs administered to diagnose and treat infertility. Excludes in vitro fertilization, ovum transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and reversal of voluntary sterilization.</i>	50% of covered charges
AMBULANCE	
<i>Air/Ground Ambulance Services when medically necessary</i>	No charge
EMERGENCY SERVICES	
<i>Waived if hospitalized</i>	\$50/visit
MENTAL HEALTH	
<p>Inpatient <i>No limits for severe mental illness of a child or adult or emotional disturbance of a child.</i></p> <p><i>Up to 30 days/calendar year for treatment of acute phase of mental health conditions during certified confinement in participating hospital.</i></p>	No charge
<p>Outpatient <i>For severe mental illness of a child or adult or emotional disturbance of a child.</i></p>	\$10/visit (no visit limits)
<p><i>Evaluation, crisis intervention and treatment for other mental health conditions.</i></p>	\$20/visit (up to 20 visits/calendar year)
SUBSTANCE ABUSE TREATMENT	
<p>Inpatient <i>Acute medical detoxification only</i></p>	No charge
<p>Outpatient <i>Evaluation, crisis intervention, and treatment for conditions subject to significant improvement through short-term therapy.</i></p>	\$10/visit (up to 20 visits/calendar year)

(continued on next page)

BENEFITS	Copay and/or Benefit Limits
HOME HEALTH SERVICES	
<i>Custodial care not covered.</i>	No charge
SKILLED NURSING FACILITY CARE	
<i>Medically necessary services provided in licensed skilled nursing facility. Custodial care not covered.</i>	No charge (up to 100 days/calendar year)
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
Inpatient - hospital or skilled nursing facility	No charge
Outpatient - office and home visits	\$10/visit
HOSPICE	
	No charge
ACUPUNCTURE	
	Not covered
CHIROPRACTIC	
<i>Offered by Kaiser Permanente and Western Health Advantage</i>	\$10/visit (up to 20 visits/calendar year)
BLOOD & BLOOD PRODUCTS	
	No charge
HEARING AID SERVICES	
Audiological exam	No charge
Hearing aids	\$1,000 maximum (every 36 months)

* Blue Shield provides an Exclusive Provider Organization (EPO) instead of an HMO in the following counties: Colusa, Lake, Mendocino, Plumas, Sierra and parts of El Dorado. The EPO provides the same benefits as the HMO plan, but in the EPO, members receive care from providers in Blue Shield's PPO provider network and members are not required to select a primary care physician (PCP). Contact Blue Shield for more information about the EPO and its PPO provider network.

PPO Basic Plans, PERSCare & PERS Choice

BENEFITS	PERSCare		PERS Choice	
PLAN YEAR DEDUCTIBLE				
	Your Cost		Your Cost	
Member	\$500		\$500	
Family	\$1,000		\$1,000	
MAXIMUM PLAN YEAR COPAYMENT*				
Member	\$2,000		\$3,000	
Family	\$4,000		\$6,000	
LIFETIME MAXIMUM BENEFIT				
Per individual	N/A		\$2,000,000	
MEDICAL BENEFITS				
	PPO	Non-PPO	PPO	Non-PPO
Hospital - Inpatient and Outpatient <i>(\$250 deductible per admission for PERSCare Inpatient)</i>	10%	40%	20%	40%
Physician Outpatient Hospital	\$20 copay**	40%	\$20 copay**	40%
Physician Office Visits	\$20 copay**	40%	\$20 copay**	40%
Preventive Care <i>(Immunizations and periodic health exams)</i>	No charge**	40%	No charge**	40%
Other Physician Professional Services	10%	40%	20%	40%
Diagnostic X-ray and Lab	10%	40%	20%	40%
Hearing Aid Services <i>(\$1,000 maximum in 36-month period for hearing aids)</i>	10%	40%	20%	40%
Ambulance	20%	20%	20%	20%
Emergency Care Services <i>(\$50 deductible covered ER charges)</i>	10%	10%	20%	20%
Chiropractic/Acupuncture <i>(Combined benefits)</i>	10%	40%	20%	40%
Durable Medical Equipment***	10%	40%	20%	40%
Unreplaced Blood	20%	20%	20%	20%
Hospice Care <i>(\$10,000 lifetime maximum; precertification required)</i>	10%	10%	20%	20%
Speech <i>(\$5,000 lifetime maximum)</i>	10%	40%	20%	40%
Physical/Occupational Therapy <i>(\$3,500 calendar year maximum for combined physical/occupational therapy benefits for PERS Choice)</i>	20%	20%	20%	20%

BENEFITS


PERSCare

PERS Choice

MEDICAL BENEFITS *(continued)*

	PPO	Non-PPO	PPO	Non-PPO
Mental Health <i>(Includes mental health parity provisions)</i>				
Inpatient <i>(\$250 deductible per admission for PERSCare)</i>	10% <i>(up to 30 days per calendar year)</i>	40%	20% <i>(up to 20 days per calendar year)</i>	40%
Outpatient <i>(Precertification required at first visit)</i>	10% <i>(up to 30 visits per calendar year)</i>	40%	20% <i>(up to 24 visits per calendar year)</i>	40%
Chemical Dependency <i>(\$12,000 lifetime maximum for any combination of inpatient and outpatient benefits)</i>				
Inpatient**** <i>(Precertification required)</i>	10% <i>(up to 15 days per calendar year)</i>	40%	20% <i>(up to 20 days per calendar year)</i>	40%
Outpatient <i>(Precertification required)</i>	10% <i>(up to 30 visits per calendar year)</i>	40%	20% <i>(up to 24 visits per calendar year)</i>	40%
Home Health Care <i>(Precertification required)</i>	10% <i>(up to 100 visits per calendar year)</i>	40%	20% <i>(up to \$6,000 per calendar year)</i>	40%
Skilled Nursing Facility <i>(Precertification required)</i>				
First 10 Days	10%	40%	20%	40%
	20% <i>(next 170 days)</i>	40%	30% <i>(next 90 days)</i>	40%

PRESCRIPTION DRUG BENEFITS

 Retail Pharmacy Program PERSCare <i>(up to 34-day supply)</i> PERS Choice <i>(up to 30-day supply)</i>	\$5/generic \$15/formulary brand name \$45/non-formulary brand name <i>(\$30 if medically necessary waiver obtained)‡</i>	\$5/generic \$15/formulary brand name \$45/non-formulary brand name <i>(\$30 if medically necessary waiver obtained)‡</i>
Mail Service Program <i>(A \$1,000 maximum copayment per person per calendar year applies up to 90-day supply)</i>	\$10/generic \$25/formulary brand name \$75/non-formulary brand name <i>(\$45 if medically necessary waiver obtained)‡</i>	\$10/generic \$25/formulary brand name \$75/non-formulary brand name <i>(\$45 if medically necessary waiver obtained)‡</i>

* The maximum plan year copayment applies when: (1) covered services are received from a Preferred Provider or (2) if you live and receive covered services OUTSIDE a Preferred Provider area. If you live WITHIN a Preferred Provider area, covered services received from Non-Preferred Providers, even if referred by a Preferred Provider, do NOT apply toward the maximum calendar year copayment.

** These services are NOT subject to the calendar year deductible if received from a Preferred Provider.

*** Precertification for durable medical equipment priced at \$1,000 or more required for PERSCare. A \$3,000 calendar year maximum for durable medical equipment applies for PERS Choice.

**** A \$250 hospital admission deductible applies for each admission for PERSCare.

‡ Medically necessary waivers can be obtained through Caremark's formal appeals process.

HMO Medicare Plans

	Supplement to Original Medicare Plans	Medicare Managed Care Plan (Medicare + Choice)
	Blue Shield of California* Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	Copay and/or Benefit Limits	Copay and/or Benefit Limits
HOSPITAL		
Inpatient	No charge	No charge
Outpatient	No charge	No charge
PHYSICIAN SERVICES		
Office Visits <i>Includes allergy testing/treatment, gynecological exam, and vision exam (refraction)</i>	\$10/visit	\$10/visit
Periodic Health Exam	\$10/visit	\$10/visit
Immunization/Inoculation	\$10/immunization	\$10/immunization
Vision Exam (Refraction)	\$10 in network	\$10
Inpatient Hospital Visits	No charge	No charge
Surgery/Anesthesia	No charge	No charge
DIAGNOSTIC X-RAY/LAB		
Outpatient Services	No charge	No charge
PRESCRIPTION DRUGS		
Retail Pharmacy <i>(up to 30-day supply)</i>	\$5/generic \$15/formulary brand name \$45/non-formulary (<i>\$30 if medical necessity approved</i>)	\$5/generic \$15/brand name <i>Kaiser Permanente provides up to 100-day supply (or a 30-day supply for certain drugs) through its pharmacies or mail order program.</i>
Mail Order Program <i>(up to 90-day supply) \$1,000 maximum copayment per person per calendar year .</i>	\$10/generic \$25/formulary brand name \$75/non-formulary (<i>\$45 if medical necessity approved</i>)	
DURABLE MEDICAL EQUIPMENT		
	No charge	No charge
AMBULANCE		
<i>Air/Ground ambulance services when medically necessary</i>	No charge	No charge

Supplement to Original Medicare and Medicare Managed Care

	Supplement to Original Medicare Plans	Medicare Managed Care Plan (Medicare + Choice)
	Blue Shield of California* Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	Copay and/or Benefit Limits	Copay and/or Benefit Limits
EMERGENCY SERVICES		
<i>Waived if hospitalized</i>	\$50/visit	\$50/visit
MENTAL HEALTH		
Inpatient	No charge; certain limits apply. Refer to EOC	No charge; up to 45 days/year after Medicare's 190 lifetime days are exhausted. <i>(Limits not applied to certain conditions; see EOC.)</i>
Outpatient	\$10 - \$20/visit; refer to EOC	\$10/visit
SUBSTANCE ABUSE TREATMENT		
Inpatient <i>Acute medical detoxification only</i>	No charge	No charge
Outpatient	\$10/visit; up to 20 visits/calendar year	\$10/visit; up to 20 visits/calendar year
HOME HEALTH SERVICES		
<i>Custodial care not covered</i>	No charge	No charge
SKILLED NURSING FACILITY CARE		
<i>Medically necessary services provided in licensed skilled nursing facility. Custodial care not covered.</i>	No charge <i>(up to maximum 100 days per Medicare benefit period)</i>	No charge
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY		
	\$10/visit	\$10/visit
HOSPICE		
	No charge	No charge
ACUPUNCTURE		
	Not covered	Not covered

(continued on next page)

HMO Medicare Plans

	Supplement to Original Medicare Plans	Medicare Managed Care Plan (Medicare + Choice)
	Blue Shield of California* Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	Copay and/or Benefit Limits	Copay and/or Benefit Limits
CHIROPRACTIC		
Services covered by Medicare	\$10/visit <i>Western Health Advantage allows 20 visits/year beyond Medicare benefit</i>	\$10/visit <i>Kaiser allows 20 visits/year beyond Medicare benefit</i>
BLOOD & BLOOD PRODUCTS		
	No charge	No charge
HEARING AID SERVICES		
Audiological Exam	No charge	No charge
Hearing Aid	\$1,000 maximum (<i>every 36 months</i>)	\$1,000 maximum (<i>every 36 months</i>)

* Blue Shield provides an Exclusive Provider Organization (EPO) instead of an HMO in the following counties: Colusa, Lake, Mendocino, Plumas, Sierra and parts of El Dorado. The EPO provides the same benefits as the HMO plan, but in the EPO, members receive care from providers in Blue Shield's PPO provider network and members are not required to select a primary care physician (PCP). Contact Blue Shield for more information about the EPO and its PPO provider network.

PERSCare & PERS Choice Supplement Plans

BENEFITS	PERSCare	PERS Choice
PLAN YEAR DEDUCTIBLE		
	Plan pays Medicare Parts A and B deductible	Plan pays Medicare Parts A and B deductible
LIFETIME MAXIMUM BENEFIT		
	None	\$2,000,000 per individual
MEDICAL BENEFITS		
Hospital, Inpatient and Outpatient	No charge*†	No charge*
Physician Office/Home/Hospital Visits	No charge*	No charge*
Gynecological Exam	No charge*	No charge*
Allergy Testing/Treatment	No charge*	No charge*
Diagnostic X-Ray/Lab	No charge*	No charge*
Ambulance	No charge*	No charge*
Emergency Services	No charge*	No charge*
Home Health Services	No charge*	No charge*
Durable Medical Equipment	No charge*	No charge*
Hearing Aid Services	20%**	20%***
Mental Health		
Inpatient	No charge*†	No charge*
Outpatient - includes outpatient substance abuse treatment (<i>Medicare pays 50% of the approved amount for most services.</i>)	Excess charges*†	Excess charges*
Skilled Nursing Facility Care		
<i>Up to 100 days each benefit period in a Medicare-approved facility.</i>	No charge*	No charge*
<i>From 101 to 365 days (must be precertified by Blue Cross)</i>	20%†	Not covered
Speech Therapy	No charge*† \$5,000 lifetime maximum	No charge*
Physical Therapy	No charge*†	No charge*
Occupational Therapy	No charge*†	No charge*

PPO Supplement to Medicare Plans

BENEFITS	PERSCare	PERS Choice
MEDICAL BENEFITS <i>(continued)</i>		
Acupuncture <i>(20 visits per calendar year)</i>	20%†	Not covered
Biofeedback	No charge*	Not covered
Chiropractic	No charge*	No charge*
Diabetes Services <i>Includes diabetes self-management training, glucose monitors, test strips, lancets, etc.</i>	No charge*	No charge*
Heart Transplants	No charge*	No charge*
Kidney Dialysis and Transplants	No charge*	No charge*
Hospice Care	No charge*	No charge*
Podiatrists' Services	No charge*	No charge*
Christian Science Treatment	No charge*	No charge*
Unreplaced Blood and Blood Products	20%†	No charge* <i>(all but the first three pints per calendar year)</i>
VISION CARE		
One exam and two lenses per calendar year; one set of frames during a 24-month period Maximum Allowances: Exam \$35; Frames \$30; Each Lens: Single Vision \$20; Bifocal \$35; Trifocal \$45; Lenticular \$50; Contact Lenses \$100	Any amount in excess of the maximum allowance †	Any amount in excess of the maximum allowance †
PRESCRIPTION DRUGS		
Retail Pharmacy Program	\$5/generic \$15/formulary brand name \$45/non-formulary brand name <i>(\$30 if medically necessary waiver obtained)‡</i> <i>(up to 34-day supply)</i>	\$5/generic \$15/formulary brand name \$45/non-formulary brand name <i>(\$30 if medically necessary waiver obtained)‡</i> <i>(up to 30-day supply)</i>

(continued on next page)

‡ Medically necessary waivers for non-formulary brand name drugs can be obtained through Caremark's formal appeals process.

PERSCare & PERS Choice Supplement Plans

BENEFITS	PERSCare	PERS Choice
PRESCRIPTION DRUGS <i>(continued)</i>		
Mail Service Program <i>(A \$1,000 maximum copayment per person per calendar year applies) (up to 90-day supply)</i>	\$10/generic \$25/formulary brand name \$75/non-formulary brand name <i>(\$45 if medically necessary waiver obtained)‡</i>	\$10/generic \$25/formulary brand name \$75/non-formulary brand name <i>(\$45 if medically necessary waiver obtained)‡</i>
BENEFITS BEYOND MEDICARE		
Hearing Aid Services	Yes ^{**†}	Yes ^{***†}
Vision Care	Yes [†]	Yes [†]
Skilled Nursing Facility	Yes [†]	No
Acupuncture	Yes [†]	No
Physical Therapy	Yes [†]	No
Speech Therapy	Yes [†]	No
Occupational Therapy	Yes [†]	No
Mental Health Services	Yes [†]	No

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

† This is a benefit beyond Medicare.

** PERSCare pays 80% of Blue Cross of California's Allowable Amount for hearing aid services, subject to a maximum payment of \$2,000 per member once every 24 months.

*** PERS Choice pays 80% of Blue Cross of California's Allowable Amount for hearing aid services, subject to a maximum payment of \$1,000 per member once every 36 months.

CCPOA Association Plans (HMO)

BENEFITS	HMO Copay/Limits *
HOSPITAL	
Inpatient	No charge Tier I (HMO) Not covered Tier II (PPO)
Outpatient Surgery	No charge Tier I (HMO) Not covered Tier II (PPO)
PHYSICIAN SERVICES	
Office Visits	\$10 Tier I (HMO) \$20 Tier II (PPO)
Gynecological Exam	\$10 Tier I (HMO) \$20 Tier II (PPO)
Periodic Health Exam	\$10 Tier I (HMO) \$20 Tier II (PPO)
Well-Baby Care	\$10 Tier I (HMO) \$20 Tier II (PPO)
Allergy Testing/Treatment	No charge Tier I (HMO) \$20 Tier II (PPO)
Immunization/Inoculation	No charge
Vision Exam (Refraction)	\$10 Tier I (HMO) \$20 Tier II (PPO)
Hearing Exam/Screening	\$10 Tier I (HMO) \$20 Tier II (PPO)
Inpatient Hospital Visits	No charge Tier I (HMO) Not covered Tier II (PPO)
Surgery/Anesthesia <i>See EOC for Tier II (PPO) details.</i>	No charge Tier I (HMO) Not covered Tier II (PPO)
DIAGNOSTIC X-RAY/LAB	
	No charge Tier I (HMO) No charge Tier II (PPO) when performed in physician's office
PRESCRIPTION DRUGS	
Retail Pharmacy <i>(up to 30-day supply)</i>	\$5/generic \$20/formulary brand name \$35/non-formulary
Mail Order Program <i>(90-day supply)</i>	\$10/generic \$40/formulary brand name \$70/non-formulary

Basic Plan – Regions: North¹ and South²

BENEFITS	HMO Copay/Limits
DURABLE MEDICAL EQUIPMENT	No charge Tier I (HMO) Not covered Tier II (PPO)
INFERTILITY TESTING/TREATMENT	50% Tier I (HMO) Not covered Tier II (PPO)
AMBULANCE	No charge
EMERGENCY SERVICES	\$75/visit; waived if admitted
MENTAL HEALTH	
Inpatient	No charge Tier I (HMO) Not covered Tier II (PPO)
Outpatient	\$20/visit (20 visits/year)
SUBSTANCE ABUSE TREATMENT	
Inpatient	No charge Tier I (HMO) (30 days/year) Not covered Tier II (PPO)
Outpatient	\$10/visit (20 visits/year) Tier I (HMO) Not covered Tier II (PPO)
HOME HEALTH SERVICES	
	\$10/visit Tier I (HMO) Not covered Tier II (PPO)
SKILLED NURSING FACILITY CARE	
	No charge Tier I (HMO) (up to 100 days/yr) Not covered Tier II (HMO)
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
	No charge Tier I (HMO) \$20/visit Tier II (PPO) (12 visits combined/year Tier II (PPO))
HOSPICE	
	No charge Tier I (HMO) (\$5,000 lifetime maximum) Not covered Tier II (PPO)

(continued on next page)

CCPOA Association Plans (HMO)

BENEFITS	HMO Copay/Limits
ACUPUNCTURE	Not covered
CHIROPRACTIC	\$10/visit Tier I (HMO) (20 visits/year maximum) Not covered Tier II (PPO)
BLOOD & BLOOD PRODUCTS	No charge
HEARING AID SERVICES	
Audiological Exam	\$10 Tier I (HMO) \$20 Tier II (PPO)
Hearing Aid	Annual \$500 maximum allowance toward one or more hearing aids or devices - Tier I (HMO) Not covered Tier II (PPO)

1 Northern region includes these counties: Alameda, Contra Costa, El Dorado+, Fresno+, Kings, Madera, Marin, Merced, Napa, Nevada+, Placer+, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare & Yolo
(+ Some ZIP codes in these counties are restricted to existing members with the exception of dependents of existing members. See EOC).

2 Southern region includes these counties: Kern+, Los Angeles+, Orange, Riverside+, San Bernardino+, San Diego+, Santa Barbara, & Ventura
(+ Some ZIP codes in these counties are restricted to existing members with the exception of dependents of existing members. See EOC).

* In Tier I, members receive care within the HMO network and care is coordinated by your PCP. In Tier II, members may see specialists within the PPO network without PCP referral.

CCPOA Association Plans (HMO)

BENEFITS	HMO Copay/Limits
HOSPITAL	
Inpatient	No charge
Outpatient Surgery	No charge
PHYSICIAN SERVICES	
Office Visits	\$5/visit
Gynecological Exam	No charge
Periodic Health Exam	No charge
Allergy Testing/Treatment	No charge
Immunization/Inoculation	No charge
Vision Exam (Refraction)	No charge
Hearing Exam/Screening	No charge
Inpatient Hospital Visits	No charge
Surgery/Anesthesia	No charge
DIAGNOSTIC X-RAY/LAB	
	No charge
PRESCRIPTION DRUGS	
Retail Program <i>(up to 30-day supply)</i>	\$5/generic \$20/formulary brand name \$35/non-formulary
Mail Order Program <i>(90-day supply)</i>	\$10/generic \$40/formulary brand name \$70/non-formulary
DURABLE MEDICAL EQUIPMENT	
	No charge
AMBULANCE	
	No charge
EMERGENCY SERVICES	
	No charge
MENTAL HEALTH	
Inpatient	No charge <i>(190 day lifetime maximum)</i>
Outpatient	\$5/visit <i>(20 visits/year)</i>

Medicare Supplement – Regions: North¹ and South²

BENEFITS	HMO Copay/Limits
SUBSTANCE ABUSE TREATMENT	
Inpatient	No charge
Outpatient	\$5/visit
HOME HEALTH SERVICES	
	No charge
SKILLED NURSING FACILITY CARE	
	No charge (<i>up to 100 days per Medicare benefit period</i>)
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
	No charge
HOSPICE	
	No charge
ACUPUNCTURE	
	Not covered
BIOFEEDBACK	
	No charge
CHIROPRACTIC	
	Not covered
BLOOD & BLOOD PRODUCTS	
	No charge
HEARING AID SERVICES	
Audiological Exam	No charge
Hearing Aid	Annual \$500 maximum allowance toward one or more hearing aids or devices

1 Northern region includes these counties: Alameda, Contra Costa, El Dorado+, Fresno+, Kings, Madera, Marin, Merced, Napa, Nevada+, Placer+, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare & Yolo
 (+ Some ZIP codes in these counties are restricted to existing members with the exception of dependents of existing members. See EOC).

2 Southern region includes these counties: Kern+, Los Angeles+, Orange, Riverside+, San Bernardino+, San Diego+, Santa Barbara, & Ventura
 (+ Some ZIP codes in these counties are restricted to existing members with the exception of dependents of existing members. See EOC).

CAHP & PORAC Association Plans (PPOs)

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO*	PPO	Non-PPO*
HOSPITAL				
Inpatient	10%	Varies. See EOC	10%	10% (<i>varies</i>)
Outpatient	10%	40%	10%	10% (<i>varies</i>)
PHYSICIAN SERVICES				
Office Visits	\$15 (<i>waived for preventive care</i>)	40%	\$20 (<i>deductible does not apply</i>)	10%
Gynecological Exam	Included in periodic health exam	Included in periodic health exam	Included in periodic health exam	Included in periodic health exam
Periodic Health Exam	No charge; \$300/yr maximum;** Subscriber, spouse & dependents age 7+	No charge; \$300/yr maximum;** Subscriber, spouse & dependents age 7+	No charge; \$500/yr maximum;** Subscriber, spouse & child age 17+ <i>(includes electron beam tomography for subscriber only)</i>	No charge; \$500/yr maximum;** Subscriber, spouse & child age 17+
Well-Child Care	No charge & unlimited visits under age 7	No charge & unlimited visits under age 7	No charge; \$500/year maximum**	No charge; \$500/year maximum**
Allergy Testing/Treatment	10%	40%	10%	10%
Immunization/Inoculation	10%	40%	Included in well-baby/child care	Included in well-baby/child care
	<i>(Unless part of well-baby care or periodic health exam)</i>			
Vision Exam (Refraction)	Not covered	Not covered	Not covered	Not covered
Hearing Exam/Screening	10%; \$200/maximum** <i>(per 36 months)</i>	40%; \$200/maximum** <i>(per 36 months)</i>	20%; maximum \$50/exam with hearing aid purchase**	20%; maximum \$50/exam with hearing aid purchase**
Inpatient Hospital Visits	10%	40%	10%	10% (<i>varies</i>)
Surgery/Anesthesia	10%	40%	10%	10% (<i>varies</i>)
DIAGNOSTIC X-RAY/LAB				
	10%	40%	10%	10% (<i>varies</i>)

Basic Plans

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO*	PPO	Non-PPO*
PRESCRIPTION DRUGS				
Retail Pharmacy <i>CAHP: up to 30-day supply</i>	\$5/generic \$20/single source \$25/multi-source	\$5/generic \$20/single source \$25/multi-source	\$5/generic \$20/formulary \$35/non-formulary brand name	Limited fee schedule brand name
<i>PORAC: up to 34 day supply or 100 pills/units, whichever is more</i>				
Mail Order Program <i>CAHP: 90 day supply</i>	\$10/generic \$40/single source \$50/multi-source	\$10/generic \$40/single source \$50/multi-source	\$10/generic \$30/formulary \$50/non-formulary brand name	Not applicable brand name
<i>PORAC: 90 day supply or 100 pills/units, whichever is more</i>				
DURABLE MEDICAL EQUIPMENT				
	10%	40%	20%	20%
INFERTILITY TESTING/TREATMENT				
	Not covered	Not covered	Limited benefits	Limited benefits
AMBULANCE				
	20%	20%	20%	20%
EMERGENCY SERVICES				
Emergency	\$25 + 10%	\$25 + 10%	10%	10% (<i>varies</i>)
Non-emergency	\$25 + 10%	\$25 + 40%	50%	50% (<i>varies</i>)
MENTAL HEALTH				
Inpatient	See EOC	See EOC	See EOC	See EOC
Outpatient	See EOC	See EOC	See EOC	See EOC
SUBSTANCE ABUSE TREATMENT				
All covered services <i>(inpatient and outpatient)</i>	\$30,000 lifetime maximum; \$15,000 maximum/year	\$30,000 lifetime maximum; \$15,000 maximum/year	\$30,000 lifetime maximum; \$15,000 maximum/year	\$30,000 lifetime maximum; \$15,000 maximum/year
HOME HEALTH SERVICES				
	10% <i>(up to 90 visits/period of disability** See EOC)</i>	40% <i>(up to 90 visits/period of disability** See EOC)</i>	10%; 100 visits maximum/year combined PPO/non-PPO	10%; 100 visits maximum/year combined PPO/non-PPO

(continued on next page)

CAHP & PORAC Association Plans (PPOs)

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO*	PPO	Non-PPO*
SKILLED NURSING FACILITY CARE				
	10% (for up to 100 days/confinement)**	40% (for up to 100 days/confinement)**	10% (for up to 100 days/year)**	10% (for up to 100 days/year)**
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY				
Speech	10%	40%	10%	10%
Physical	10%	40%	\$20/office visit (no deductible); 10% on all other charges; 20 visits/year	10% maximum coverage \$35/visit \$700/total services obtained
Occupational	10%	40%	\$20/office visit (no deductible); 10% on all other charges; 20 visits/year	10%
HOSPICE				
	No charge (\$7,500 lifetime maximum)**	No charge	10%	10%
ACUPUNCTURE				
	10%; 20 visits/year combined chiropractic and acupuncture**	40%; 20 visits/year combined chiropractic and acupuncture**	10%	10%
CHIROPRACTIC				
	See Acupuncture	See Acupuncture	Maximum combined with Physical & Occupational Therapy	Maximum combined with Physical & Occupational Therapy
BLOOD & BLOOD PRODUCTS				
	20%	20%	20%	20%
HEARING AID SERVICES				
	10%; \$1,000 maximum/36 months**	40%; \$1,000 maximum/36 months**	20%; \$450 per ear/36 months**	20%; \$450 per ear/36 months**

Basic Plans

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO*	PPO	Non-PPO*
DEDUCTIBLES	None	None	\$300/individual or \$900/family	\$600/individual or \$1,800/family
OUT-OF POCKET MAXIMUM	\$2,000/member \$4,000/family	None	\$5,000/member (Combined PPO and non-PPO)	\$5,000/member (Combined PPO and non-PPO)
LIFETIME MAXIMUM	\$2,000,000	\$2,000,000	none	none

* Additional restrictions and limitations may apply to services obtained from a non-PPO provider. See EOC.

** Limits apply to combined total of services obtained from PPO and non-PPO providers.

CAHP & PORAC Association Plans (PPOs)

BENEFITS	CAHP Copays/Limits*	PORAC Copays/Limits*
HOSPITAL		
Inpatient	No charge	No charge. Plan pays after Medicare benefits are exhausted. See EOC
Outpatient	No charge	No charge
PHYSICIAN SERVICES		
Office Visits	\$10 visit	No charge
Gynecological Exam	No charge	No charge
Periodic Health Exam	No charge	Not covered
Allergy Testing/Treatment	No charge	No charge
Immunization/Inoculation	No charge	No charge
Vision Exam (Refraction)	Not covered	20%; \$40 maximum frames and lens combined
Hearing Exam/Screening	No charge	20%; \$50/exam in connection with hearing aid purchase
Inpatient Hospital Visits	No charge	No charge
Surgery/Anesthesia	No charge	No charge
DIAGNOSTIC X-RAY/LAB		
	No charge	No charge
PRESCRIPTION DRUGS		
Retail Pharmacy <i>(up to 30-day supply)</i>	\$5/generic \$20/single source \$25/multi-source	PPO Provider: \$5/generic \$20/formulary brand name \$35/non-formulary brand name
PORAC \$50 deductible/member for retail only.		Non-PPO: Limited to strict fee schedule.
Mail Order Program <i>(90-day supply)</i>	\$10/generic \$40/single source \$50/multi-source	\$10/generic \$30/formulary brand name \$50/formulary brand name
DURABLE MEDICAL EQUIPMENT		
	No charge	No charge
AMBULANCE		
	No charge	No charge
EMERGENCY SERVICES		
	No charge	No charge

Medicare Supplement

BENEFITS	CAHP Copays/Limits*	PORAC Copays/Limits*
MENTAL HEALTH		
Inpatient	No charge	No charge
Outpatient	See EOC	No charge; 50% Major Medical limited benefits. See EOC
SUBSTANCE ABUSE TREATMENT		
Inpatient	No charge	Not covered unless Medicare approved
Outpatient	No charge	Not covered unless Medicare approved
HOME HEALTH SERVICES		
	No charge	No charge
SKILLED NURSING FACILITY CARE		
	No charge; 20% after Medicare benefits exhausted	No charge; plan pays after Medicare benefits exhausted. See EOC
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY		
	No charge Speech: \$5,000 lifetime maximum	No charge
HOSPICE		
	No charge. \$7,500 lifetime maximum	No charge
ACUPUNCTURE		
	No charge; 20% if not Medicare approved	20% Major Medical benefits
BIOFEEDBACK		
	No charge; 20% if not Medicare approved	See EOC
CHIROPRACTIC		
	No charge; 20% if not Medicare approved	No charge; 20% Major Medical benefits. See EOC
BLOOD & BLOOD PRODUCTS		
	20% first three units	No charge first three units; 20% Major Medical benefits

(continued on next page)

CAHP & PORAC Association Plans (PPOs)

BENEFITS	CAHP Copays/Limits*	PORAC Copays/Limits*
HEARING AID SERVICES		
Audiological Exam	No charge; 10% if not Medicare approved; \$200/maximum per 36 months	20%; \$50/exam in connection with hearing aid purchase
Hearing Aid	10%; \$1,000 maximum per 36 months	20%; \$450/ear per 36 months
HEALTH EDUCATION CLASSES		
	No charge	Not covered
DEDUCTIBLES		
	\$100/individual \$200/family (<i>Major Medical deductible</i>)	\$100/individual \$200/family (<i>Major Medical deductible</i>)

NOTES

Plan Service Area: To determine what plans are available, refer to the Health Plan Service Area chart in your *Health Plan Decision Guide*.

Note: These health plans require some services to be pre-approved and/or obtained from specified doctors, hospitals, pharmacies, and other health care providers who contract with the plan. Refer to the plan's *Evidence of Coverage* booklet for further information.



California Public Employees' Retirement System

400 P Street, Sacramento, CA 95814

www.calpers.ca.gov