Montebello Unified School District

CalPERS 2018 PLAN SUMMARY COMPARISON: Active and Early Retirees - Los Angeles Area

	HMO PLANS		PPO PLANS							
	ALL CalPERS HMO PLANS: Anthem Select HMO | Anthem Traditional HMO |Blue Shield Access+ |HealthNet Smart Care | HealthNet Salud Y Mas | UnitedHealthCare	***PERS Kaiser California***	***PERS Select (80% PPO Plan)***		***PERS Choice (80% PPO Plan)***		***PERS CARE PPO (90% PPO Plan)***		***PORAC (ASSOCIATION PLAN)***	
Calendar Year Deductible			***In Network***	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***	***In Network***	***Out of Network***
Individual	$0	$0	$500	$500	$500	$500	$500	$500	$300	$600
Family	$0	$0	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$900	$1,800
							$250 per inpatient hospitalization			
Calendar Year Coinsurance Max (Excluding Rx Drug and Co-Pay)										
Individual	$1,500	$1,500	$5,150	UNLIMITED	$5,150	UNLIMITED	$5,150	UNLIMITED	$3,000	
Family	$3,000	$3,000	$10,300	UNLIMITED	$10,300	UNLIMITED	$10,300	UNLIMITED	$6,000	
Out of Pocket Max (Includes Rx, Deductible, Coinsurance and Co-pay)										
Individual	$7,350	$7,350	$7,350	UNLIMITED	$7,350	UNLIMITED	$7,350	UNLIMITED	$6,000	
Family	$14,700	$14,700	$14,700	UNLIMITED	$14,700	UNLIMITED	$14,700	UNLIMITED	$12,000	
Hospital										
Deductible (per admit)	$0	$0					$250	$250		
Inpatient Copay (per admit)	$0	$0	20% - 30%	40%	20%	40%	10%	40%	10%	10%
Outpatient Facility / Surgery Services	$0	$15	20% - 30%	40%	20%	40%	10%	40%	10%	10%
Mental Health and Substance Abuse										
Deductible (per admission)	$0	$0					$250	$250		
Inpatient Copay (per admit)	$0	$0	20% - 30%	40%	20%	40%	10%	40%	10%	10%
Outpatient Facility	$15	$15	20% - 30%	40%	20%	40%	10%	40%	10%	10%
Emergency Services										
Deductible (waived if admitted)	$0	$0	*$50	*$50	*$50	*$50	*$50	*$50	$0	$0
Emergency (waived if admitted)	$50	$50	20%	20%	20%	20%	10%	10%	10%	10%
Non-Emergency (waived if admitted)	$50	$50	20%	40%	20%	40%	10%	40%	50%	50%

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Physician Services (Includes Mental Health and Substance Abuse)										
In-Network Prevention 100%	$0	$0	$0	40%	$0	40%	$0	40%	$0	10%
Office Visits - Primary	$15	$15	$20 Copay	40%	$20 Copay	40%	$20 Copay	40%	$20 Copay	10%
Office Visits - Specialist	$15	$15	$20 Copay	40%	$20 Copay	40%	$20 Copay	40%	$20 Copay	10%
Inpatient Visits	$0	$0	20%	40%	20%	40%	10%	40%	10%	10%
Outpatient Visits	$15	$15	$20 Copay	40%	$20 Copay	40%	$20 Copay	40%	10%	10%
Urgent Care Visits	$15	$15	$20 Copay	40%	$20 Copay	40%	$20 Copay	40%	10%	10%
Vision Exam/Screening	$0	$0	Not Covered	Not Covered	Not Covered	Not covered	Not Covered	Not covered	Not Covered	Not covered
Surgery/Anesthesia	$0	$0	20%	40%	20%	40%	10%	40%	10%	10%
Diagnostic X-Ray/Lab										
Lab and X-Ray	$0	$0	20%	40%	20%	40%	10%	40%	10%	10%
Advanced Imaging (CT, MRI, PET)	$0	$0	20%	40%	20%	40%	10%	40%	10%	10%
Infertility										
	50%	50%	Not Covered	Not Covered	Not Covered	Not covered	Not Covered	Not covered	50%	50%
Prescription Drugs										
Deductible	$0	$0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Retail Pharmacy	***$5,850 Annual Max copay per member / $11,700 per Family for Pharmacy Benefits***		***$2,000 Annual Max Prescription Drug copay per member / $4,000 per Family for Retail Pharmacy Benefits on PERS PPO Plans***						***$3,000 Annual Max per member / $6,000 per Family***	
Generic	*$5*	$5	$5	Not covered	$5	Not covered	$5	Not covered	$10	Not covered
Brand - Formulary	*$20*	$20	$20	Not covered	$20	Not covered	$20	Not covered	$25	Not covered
Non-Formulary	*$50*	$20	$50	Not covered	$50	Not covered	$50	Not covered	$45	Not covered
Mail Order	***$1,000 per member copay max for Mail Order on non-KP HMO***		***$1,000 Annual Max copay per member for Mail Order Pharmacy Benefits on PERS PPO Plans***							
Generic-Formulary	*$10*	$10	$10	Not covered	$10	Not covered	$10	Not covered	$20	Not covered
Brand - Formulary	*$40*	$40	$40	Not covered	$40	Not covered	$40	Not covered	$40	Not covered
Non-Formulary	*$100*	$40	$100	Not covered	$100	Not covered	$100	Not covered	$75	Not covered
Durable Medical Equipment										
	$0	$0	20%	40%	20%	40%	10%	40%	20%	20%
Home Health Services										
	$15	$15	20%	40%	20%	40%	10%	40%	$20	10%
Skilled Nursing Care										
Hospital	$0	$0	20%	40%	20%	40%	10%	40%	10%	10%
Occupational / Physical / Speech Therapy										
Inpatient	$0	$0	0%	0%	0%	0%	0%	0%	10%	10%
Outpatient	$15	$15	20%	20% [40% Occ]	20%	20% [40% Occ]	10%	10% [40% Occ]	$20	10%

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Diabetes Services										
Glucose monitors	$0	$0	Varies	Varies	Varies	Varies	Varies	Varies	Varies	Varies
Self-management training	$15	$15	$20	$20	$20	$20	$20	$20	$20	$20
Hospice										
	$0	$0	0%	40%	0%	40%	0%	40%	0%	0%
Acupuncture	***20 Combined Visits***		***Acup/chiro combined 20 visits***		***Acup/chiro combined 20 visits***		***Acup/chiro combined 20 visits***			
* Medical Review	$15	$15	$15	40%	$15	40%	$15	40%	$20	10%
Chiropractic	***20 Combined Visits***		***Acup/chiro combined 20 visits***		***Acup/chiro combined 20 visits***		***Acup/chiro combined 20 visits***		***20 Visit Limit***	
* Medical Review	$15	$15	$15	40%	$15	40%	$15	40%	$20	$35
Eye Care										
Exam	$0	$0	Not Covered		Not Covered		Not Covered		Not Covered	
Glasses	Not Covered	Not Covered	Not Covered		Not Covered		Not Covered		Not Covered	
Hearing Aids										
	$1,000 max per member every 36 mos.	$1000 max per member every 36 mos.	Not covered		Not covered		Not covered		Not covered	
ACTUARIAL VALUE	***92.00%***	**90.40%**	**85.35%**		**87.14%**		**91.61%**		**92.68%**	

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