

CalPERS Health Plan Benefit Comparison – 2024

This chart is not intended to cover all situations and services. Please see each plan's evidence of coverage for complete coverage information.

	HMO	HMO	HMO	PPO		PPO	
BENEFITS	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Western Health Advantage	PERS Gold		PERS Platinum	
				PPO	Non-PPO ¹	PPO	Non-PPO ¹

Calendar Year Deductible

Individual	N/A	N/A	N/A	\$1,000 <small>(for in-network providers. Up to \$500 deductible credits available for certain activities)</small>	\$500 <small>(for in-network providers)</small>
Family	N/A	N/A	N/A	\$2,000 <small>(for in-network providers)</small>	\$1,000 <small>(for in-network providers)</small>

Maximum Calendar Year Co-pay (excluding pharmacy). PPO amounts are when using an in-network provider.

Individual	\$1,500	\$1,500	\$1,500	\$3,000	N/A	\$2,000	N/A
Family	\$3,000	\$3,000	\$3,000	\$6,000	N/A	\$4,000	N/A

Hospital (including Mental Health and Substance Abuse)

Deductible (per admission)	N/A	N/A	N/A	N/A		\$250	
Inpatient and Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	20%	40%	10%	40%
Mental/Behavioral Health, or Substance Abuse Services	outpatient services: \$15/ office visit; inpatient services: no charge	outpatient services: \$15/ office visit; inpatient services: no charge	outpatient services: \$15/ office visit; inpatient services: no charge	20%	40%	10%	40%

Emergency Services

Emergency Room Deductible	N/A	N/A	N/A	\$50 <small>(waived if admitted directly from the ER)</small>		\$50 <small>(waived if admitted directly from the ER)</small>	
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	20% (applies to other services such as x-ray, labs, etc.)		10% (applies to other services such as x-ray, labs, etc.)	
Non-emergency (Co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	20%	40%	10%	40%
				<small>(payment for physician charges only; emergency room facility charge is not covered)</small>		<small>(payment for physician charges only; emergency room facility charge is covered)</small>	

¹ Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the contracted amount.

	HMO	HMO	HMO	PPO		PPO	
BENEFITS	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Western Health Advantage	PERS Gold		PERS Platinum	
				PPO	Non-PPO ¹	PPO	Non-PPO ¹

Physician Services (including Mental Health and Substance Abuse)

Office Visits (standard visit to treat illness or injury)	\$15	\$15 - \$30	\$15	\$10 - \$35	40%	\$20 - \$35	40%
Inpatient Visits <small>mental/behavior health, or substance abuse</small>	No Charge	No Charge	No charge	20%	40%	10%	40%
Outpatient Visits <small>mental/behavior health, or substance abuse</small>	\$15	\$15	\$15	\$20	40%	\$20	40%
Urgent Care Visits	\$15	\$15	\$15	\$35, 20%	40%	\$35, 10%	40%
Vision Exam/Screening	No Charge	No Charge	No Charge	Not Covered		Not Covered	
Surgery/Anesthesia	No Charge	No Charge	No Charge	20%	40%	10%	40%

Diagnostic X-Ray/Lab

No Charge	No Charge	No Charge	20%	40%	10%	40%
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Occupational / Physical / Speech Therapy

Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge		No Charge	
Outpatient (office and home visits)	\$15	\$15	\$15	20%	40%; Occupational Therapy: 20%	10%	40%; Occupational Therapy: 10%
				(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)	

Diabetes Services

Glucose Monitors, test strips	No Charge	No Charge	No Charge	Coverage Varies		Coverage Varies	
Self-management training	\$15	\$15	\$15	\$10-\$35 40%	\$20-\$35 40%		

Acupuncture

\$15/visit	\$15/visit	\$15/visit	\$15	40%	\$15	40%
(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	

Chiropractic

\$15/visit	\$15/visit	\$15/visit	\$15	40%	\$15	40%
(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	

Infertility Treatment

Not Covered (unless medically necessary)	Not Covered (unless medically necessary)	Not Covered (unless medically necessary)	Not Covered (unless medically necessary)		Not Covered (unless medically necessary)	
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