

2024 CalPERS "3 Magic Plans" Basic Plans (Actives & Pre-65 Retirees)

BENEFITS	CalPERS Kaiser HMO	PERS Gold PPO		PERS Platinum PPO	
		PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible					
Individual	N/A	\$1,000*	\$2,500	\$500	\$2,000
Family	N/A	\$2,000*	\$5,000	\$1,000	\$4,000
Maximum Calendar Year Copay or Coinsurance <i>(Excluding Pharmacy)</i>					
Individual	\$1,500 <i>(copay)</i>	\$3,000 <i>(coinsurance)</i>	Unlimited	\$2,000 <i>(coinsurance)</i>	Unlimited
Family	\$3,000 <i>(copay)</i>	\$6,000 <i>(coinsurance)</i>	Unlimited	\$4,000 <i>(coinsurance)</i>	Unlimited
Hospital <i>(Including Mental Health and Substance Abuse)</i>					
Deductible <i>(per admission)</i>	N/A	N/A		\$250	
Inpatient	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
Outpatient Facility/Surgery Services	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
Emergency Services					
Emergency Room Deductible	N/A	\$50 <i>(applies to hospital emergency room facility charge only)</i>		\$50 <i>(applies to hospital emergency room facility charge only)</i>	
Emergency	\$50 <i>(copay waived if admitted as an inpatient or for observation as an outpatient)</i>	20% <i>(applies to other services such as physician, x-ray, lab, etc.)</i>		20% <i>(applies to other services such as physician, x-ray, lab, etc.)</i>	
Non-Emergency	\$50 <i>(copay waived if admitted as an inpatient or for observation as an outpatient)</i>	20% <i>(payment for physician charges only; emergency room facility charge is not covered)</i>	40%	10% <i>(payment for physician charges only; emergency room facility charge is not covered)</i>	40%
Physician Services <i>(Including Mental Health and Substance Abuse)</i>					
Office Visits <i>(copay for each service provided)</i>	\$15	\$10 if assigned PCP \$35 all other providers	40% <i>of allowable amount</i>	\$20 primary care \$35 specialists	40% <i>of allowable amount</i>
Inpatient Visits	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
Outpatient Visits	\$15	\$35	40% <i>of allowable amount</i>	\$20	40% <i>of allowable amount</i>
Urgent Care Visits	\$15	\$35	40% <i>of allowable amount</i>	\$35	40% <i>of allowable amount</i>
Preventative Services	No Charge	No Charge	40% <i>of allowable amount</i>	No Charge	40% <i>of allowable amount</i>
Sugery/Anesthesia	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
Diagnostic X-Ray/Lab	No Charge	20%**	40% <i>of allowable amount</i>	10%**	40% <i>of allowable amount</i>
Prescription Drugs					
Retail Pharmacy <i>(30-day supply)</i>	Generic: \$5 Brand: \$20	Generic: \$5 Preferred Brand: \$20 Non-Preferred Brand: \$50		Generic: \$5 Preferred Brand: \$20 Non-Preferred Brand: \$50	
Retail Preferred Pharmacy Maintenance Medications <i>(90-day supply)</i>	Generic: N/A Brand: N/A	Generic: \$10 Preferred Brand: \$40 Non-Preferred Brand: \$100		Generic: \$10 Preferred Brand: \$40 Non-Preferred Brand: \$100	
Mail Order Pharmacy Program <i>(not to exceed 90-day supply for maintenance drugs)</i>	Generic: \$10 Brand: \$40	Generic: \$10 Preferred Brand: \$40 Non-Preferred Brand: \$100		Generic: \$10 Preferred Brand: \$40 Non-Preferred Brand: \$100	
Mail Order Maximum Copayment per person per calendar year	\$1,000	\$1,000		\$1,000	
Durable Medical Equipment					
Durable Medical Equipment	No Charge	20% <i>(pre-certification required for specific equipment)</i>	40% <i>of allowable amount</i>	10% <i>(pre-certification required for the purchase of equipment priced at \$1,000 or more)</i>	40% <i>of allowable amount</i>

*incentives available to reduce individual deductible (max. \$500) and family deductible (max. \$1,000)
**For Lab only - No charge when using Quest Diagnostic or Labcorp

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