

**2025 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
<b>Calendar Year Deductible</b>					
<b>Individual</b>	N/A	\$1,000*	\$2,500	\$500	\$2,000
<b>Family</b>	N/A	\$2,000*	\$5,000	\$1,000	\$4,000
<b>Maximum Calendar Year Copay or Coinsurance</b> <i>(Excluding Pharmacy)</i>					
<b>Individual</b>	\$1,500 <i>(copay)</i>	\$3,000 <i>(coinsurance)</i>	Unlimited	\$2,000 <i>(coinsurance)</i>	Unlimited
<b>Family</b>	\$3,000 <i>(copay)</i>	\$6,000 <i>(coinsurance)</i>	Unlimited	\$4,000 <i>(coinsurance)</i>	Unlimited
<b>Hospital</b> <i>(Including Mental Health and Substance Abuse)</i>					
<b>Deductible</b> <i>(per admission)</i>	N/A	N/A		\$250	
<b>Inpatient</b>	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
<b>Outpatient Facility/Surgery Services</b>	\$15	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
<b>Emergency Services</b>					
<b>Emergency Room Deductible</b>	N/A	\$50 <i>(applies to hospital emergency room facility charge only)</i>		\$50 <i>(applies to hospital emergency room facility charge only)</i>	
<b>Emergency</b>	\$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>		10% <i>(applies to other services such as physician, x-ray, lab, etc.)</i>	
<b>Non-Emergency</b>	\$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%
<b>Physician Services</b> <i>(Including Mental Health and Substance Abuse)</i>					
<b>Office Visits</b> <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>
<b>Inpatient Visits</b>	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
<b>Outpatient Visits</b>	\$15	\$35	40% <i>of allowable amount</i>	\$20	40% <i>of allowable amount</i>
<b>Urgent Care Visits</b>	\$15	\$35	40% <i>of allowable amount</i>	\$35	40% <i>of allowable amount</i>
<b>Preventative Services</b>	No Charge	No Charge	40% <i>of allowable amount</i>	No Charge	40% <i>of allowable amount</i>
<b>Sugery/Anesthesia</b>	No Charge	20%	40% <i>of allowable amount</i>	10%	40% <i>of allowable amount</i>
<b>Diagnostic X-Ray/Lab</b>	No Charge	20%**	40% <i>of allowable amount</i>	10%**	40% <i>of allowable amount</i>
<b>Infertility Testing/Treatment</b>	50% <i>of Covered Charges</i>	50%		50%	
<b>Pregnancy &amp; Maternity Care</b>	No Charge	20%	40%	10%	40%
<b>Acupuncture</b>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	40% <i>of allowable amount</i>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	40% <i>of allowable amount</i>
<b>Chiropractic</b>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	40% <i>of allowable amount</i>	\$15/visit <i>(acupuncture/chiropractic; combined 20 visits per calendar year)</i>	40% <i>of allowable amount</i>
<b>Occupational/Physical/Speech Therapy</b>					
<b>Inpatient</b> <i>(hospital or skilled nursing facility)</i>	No Charge	No Charge		No Charge	
<b>Outpatient</b> <i>(office and home visits)</i>	\$15	10% <i>(pre-certification required for more than 24 visits)</i>	40%; Occupational Therapy: 10%	10% <i>(pre-certification required for more than 24 visits)</i>	40%; Occupational Therapy: 10%
<b>Diabetes Services</b>					
<b>Glucose Monitors</b>	No Charge	Coverage Varies		Coverage Varies	
<b>Self-management training</b>	\$15	\$20 primary care \$35 specialists	40% <i>of allowable amount</i>	\$20 primary care \$35 specialists	40% <i>of allowable amount</i>
<b>Prescription Drugs</b>					
<b>Retail Pharmacy</b> <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	
<b>Retail Preferred Pharmacy Maintenance Medications</b> <i>(90-day supply)</i>	Generic: N/A Brand: N/A	Generic: N/A Preferred Brand: N/A Non-Preferred Brand: N/A		Generic: N/A Preferred Brand: N/A Non-Preferred Brand: N/A	
<b>Mail Order Pharmacy Program</b> <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	
<b>Mail Order Maximum Copayment per person per calendar year</b>	N/A	\$1,000		\$1,000	
<b>Durable Medical Equipment</b>					
<b>Durable Medical Equipment</b>	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 services only - No charge when using Quest Diagnostic or Labcorp

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