2012 Benefits Summary Plan Comparisons - PERS PPOs (ACTIVES)

Foothill-De Anza Community College District FOR BENEFITS PERIOD OF JULY 1 - DECEMBER 31, 2012				CalPERS PPO Plans 2012 Benefits - ACTIVES ONLY					
PLAN PROVISIONS	**EPO**	**PPO**		**PERS Care**		**PERS Choice**		**PERS Select (Excludes Sutter Health/PAMF)**	
JULY 1, 2010 SUMMARY PLAN COMPARISONS				Includes access to Sutter Health/PAMF; Available for Out-0f-State residents				Services is not available in Alameda, Marin, Placer and Solano Counties; Restricted to CA Residents Only	
				Anthem Blue Cross' PRUDENT BUYER Preferred Providers Network		Anthem Blue Cross' PRUDENT BUYER Preferred Providers Network		Anthem Blue Cross' SELECT PPO Preferred Providers Network	
Plan	**In Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Plan Type	In Network Only	Open Access PPO		Open Access PPO		Open Access PPO		Select Network PPO	
Deductible (Calendar Year)	$350/ person	$350/ person	$700/person	$500/ person		$500/ person		$500/ person	
	$1,050/family	$1,050/family	$2,100/family	$1,000/family		$1,000/family		$1,000/family	
Deductible Apply to OOP max?	No	No	No	No	No maximum	No	No maximum	No	No maximum
Out-of-Pocket Annual Maximum (Only Coinsurance applies)	**$1,000/person**	$1,000/person	**$3,000/person**	**$2,000/person**	**No maximum**	**$3,000/person**	**No maximum**	**$3,000/person**	**No maximum**
	$3,000/family	$3,000/family	**$9,000/family**	**$4,000/family**	**No maximum**	**$6,000/family**	**No maximum**	**$6,000/family**	**No maximum**
Lifetime Maximum	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum	No maximum
Office Visits - Primary Care	**$25 copay**	$25 copay	**30% after Deductible**	**$20 copay**	**40% after Deductible**	**$20 copay**	**40% after Deductible**	**$20 copay**	**40% after Deductible**
Office Visits - Specialists	**$30 copay**	$30 copay	**30% after Deductible**	**$20 copay**	**40% after Deductible**	**$20 copay**	**40% after Deductible**	**$20 copay**	**40% after Deductible**
Coinsurance You Pay	**10%**	10%	**30%**	**10%**	**40%**	**20%**	**40%**	**20%**	**40%**
Hospital Copay	**$100 copay per confinement**	$100 copay per confinement	**$100 copay per confinement**	**$250 Deductible per confinement**		**$0 copay per confinement**		**$0 copay per confinement**	
Hospital Coinsurance	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Outpatient Services	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Surgery/Anesthesia	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Preventative Care	$0	$0	30% after Deductible	$0	40% after Deductible	$0	40% after Deductible	$0	40% after Deductible
Allergy Testing/Treatment	$30 copay	$30 copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Diagnostic X-ray and Lab	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
DXL with Physician OV	$25 copay	$25 copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Care	$25 copay	$25 copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Maximum Annual Visits Limit	**10 Combined Chiro/Acupuncture Visits Per Year**	**30 Combined Chiro/Acupuncture Visits Per Year**	**30 Combined Chiro/Acupuncture Visits Per Year**	**20 Combined Chiro/Acupuncture Visits Per Year**		**15 Combined Chiro/Acupuncture Visits Per Year**		**15 Combined Chiro/Acupuncture Visits Per Year**	
Acupuncture Care	$25 copay, pain therapy and nausea only	$25 copay, pain therapy and nausea only	30% after Deductible, pain therapy and nausea only	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Acupuncture Maximum Annual Visits Limit	30 Combined Chiro/Acupuncture Visits Per Year	30 Combined Chiro/Acupuncture Visits Per Year	30 Combined Chiro/Acupuncture Visits Per Year	20 Combined Chiro/Acupuncture Visits Per Year		15 Combined Chiro/Acupuncture Visits Per Year		15 Combined Chiro/Acupuncture Visits Per Year	
Urgent Care	**$30 Copay**	$30 Copay	**30% after Deductible**	**$20 Copay**	**40% after Deductible**	**$20 Copay**	**40% after Deductible**	**$20 Copay**	**40% after Deductible**
Emergency Room	**$100 Deductible (waived if admitted)**	$100 Deductible (waived if admitted)	**$100 Deductible (waived if admitted)**	**$50 ER Deductible (waived if admitted)**		**$50 ER Deductible (waived if admitted)**		**$50 ER Deductible (waived if admitted)**	
Emergency Room Services	10%	10%	10%	10%		20%		20%	
If Emergency Criteria Not Met	$100 Deductible (waived if admitted)	10% after Deductible	30% after Deductible	10% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered	20% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered	20% after Deductible - ER facility charge not covered	40% after Deductible - ER facility charge not covered
Mental Health									
Inpatient	**$100 Copay, 10% after Deductible**	$100 Copay, 10% after Deductible	**30% after Deductible**	**$250 Deductible, then 10%**	**40% after Deductible**	**20% after Deductible**	**40% after Deductible**	**20%-30% after Deductible**	**40% after Deductible**
Outpatient	$25 Copay	$25 Copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Substance Abuse									
Inpatient	$100 Copay, 10% after Deductible	$100 Copay, 10% after Deductible	30% after Deductible	$250 Deductible, then 10%	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Outpatient	$25 Copay	$25 Copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Ambulance	10% after Deductible	10% after Deductible	10% after Deductible	20% after Deductible		20% after Deductible		20% after Deductible	
Home Health Care	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Home Health Care Visit Limit	**60 per calendar year**	60 per calendar year	**60 per calendar year**	**100 visit per calendar year**		**45 visits per calendar year**		**45 visits per calendar year**	
Hospice	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible		20% after Deductible		20% after Deductible	
Hospice Care Lifetime Limit	$10,000	$10,000		No limit		No limit		No limit	
Occupational/Physical/Speech Therapy									
Inpatient	$100 Copay, 10% after Deductible	$100 Copay, 10% after Deductible	30% after Deductible	No Charge		No Charge		No Charge	
Outpatient	$30 Copay	$30 Copay	30% after Deductible	20% after Deductible		20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Pre-Certification Required				**No precert required**		**> 24 Visits**		**> 24 Visits**	
Skilled Nursing Care									
Inpatient	$100 Copay, 10% after Deductible	$100 Copay, 10% after Deductible	30% after Deductible	10% 1st 10 days, 20% next 170 days, precert req, 180 days max per year	40%, precert req, 180 days max per year	20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year	20% 1st 10 days, 30% next 90 days, precert req, 100 days max per year	40%, precert req, 100 days max per year

2012 Benefits Summary Plan Comparisons - PERS PPOs (ACTIVES)

Foothill-De Anza Community College District FOR BENEFITS PERIOD OF JULY 1 - DECEMBER 31, 2012				CalPERS PPO Plans 2012 Benefits - ACTIVES ONLY					
PLAN PROVISIONS	**EPO**	**PPO**		**PERS Care**		**PERS Choice**		**PERS Select (Excludes Sutter Health/PAMF)**	
JULY 1, 2010 SUMMARY PLAN COMPARISONS				**Includes access to Sutter Health/PAMF; Available for Out-0f-State residents**				**Services is not available in Alameda, Marin, Placer and Solano Counties; Restricted to CA Residents Only**	
				Anthem Blue Cross' PRUDENT BUYER Preferred Providers Network		**Anthem Blue Cross' PRUDENT BUYER Preferred Providers Network**		**Anthem Blue Cross' SELECT PPO Preferred Providers Network**	
Plan	**In Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Plan Type	In Network Only	Open Access PPO		**Open Access PPO**		**Open Access PPO**		**Select Network PPO**	
Outpatient	Not covered	Not covered	Not covered	Not covered		Not covered		Not covered	
Vision Exam	Not covered	Not covered	Not covered	Not covered		Not covered		Not covered	
Hearing Exam	$25 Copay	$25 Copay	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Hearing Aids	**50% after Deductible, $5,000 annual max**	50% after Deductible, $5,000 annual max	**50% after Deductible, $5,000 annual max**	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Hearing Aid Frequency	one device every 36 months	one device every 36 months		one device every 36 months		one device every 36 months		one device every 36 months	
Durable Medical Equipment	10% after Deductible	10% after Deductible	30% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
DME Precertification	**None**	None	**None**	**> $1,000**		**N/A**		**N/A**	
Prosthetic Device Limit	$10,000	$10,000	$10,000	No limit		No limit		No limit	
Infertility Services	10% after Deductible	10% after Deductible	30% after Deductible	Not covered		Not covered		Not covered	
Prescription Drug									
Retail Pharmacy Network									
Generic	$10 Copay/30 days	$10 Copay/30 days	Reimbursed at a Scheduled Amount	$5 Copay/30 days		$5 Copay/30 days		$5 Copay/30 days	
Brand Formulary	$25 Copay/30 days	$25 Copay/30 days	Reimbursed at a Scheduled Amount	$20 Copay/30 days		$20 Copay/30 days		$20 Copay/30 days	
Brand Non-Formulary	$50 Copay/30 days	$50 Copay/30 days	Reimbursed at a Scheduled Amount	$50 Copay/30 days		$50 Copay/30 days		$50 Copay/30 days	
Partial Waiver of non-preferred brand***	None	None	None	$40 Copay/30 days		$40 Copay/30 days		$40 Copay/30 days	
Retail Maintenance Choice®*									
Generic	$10 Copay/30 days	$10 Copay/30 days	Reimbursed at a Scheduled Amount	$10 Copay/90 days		$10 Copay/90 days		$10 Copay/90 days	
Brand Formulary	$25 Copay/30 days	$25 Copay/30 days	Reimbursed at a Scheduled Amount	$40 Copay/90 days		$40 Copay/90 days		$40 Copay/90 days	
Brand Non-Formulary	$50 Copay/30 days	$50 Copay/30 days	Reimbursed at a Scheduled Amount	$100 Copay90 days		$100 Copay90 days		$100 Copay90 days	
Partial Waiver of non-preferred brand***	None	None	None	$70 Copay/90 days		$70 Copay/90 days		$70 Copay/90 days	
CVS Caremark Rx Mail Service									
Generic	$20 Copay/90 days	$20 Copay/90 days	Not Available	$10 Copay/90 days	Not Available	$10 Copay/90 days	Not Available	$10 Copay/90 days	Not Available
Brand	$50 Copay/90 days	$50 Copay/90 days	Not Available	$40 Copay/90 days	Not Available	$40 Copay/90 days	Not Available	$40 Copay/90 days	Not Available
Brand Non-Formulary	$100 Copay/90 days	$100 Copay/90 days	Not Available	$100 Copay/90 days	Not Available	$100 Copay/90 days	Not Available	$100 Copay/90 days	Not Available
Partial Waiver of non-preferred brand***	None	None	None	$70 Copay/90 days		$70 Copay/90 days		$70 Copay/90 days	
Rx Copay Maximum/person**	$1,000/year	$1,000/year	$1,000/year	$1,000/year		$1,000/year		$1,000/year	

Please note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the generic copayment.

Discretionary drugs are subject to 50% co-insurance. These are products used to treat non-life threatening conditions such as erectile dysfunction.

To obtain a partial copayment waiver, your physician nust substantiate medical necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s) by faxing to CVS at 1-866-689-3092.

*Retail Maintenance Choice® are available only through CVS Drugs Stores, not offered through any other CVS contracted retail pharmacies.

**Rx Out-of-Pocket Maximum, per person each calendar year excluding non-Preferred Brand-Name Medication copayments, Distretionary Drug coinsurance, and "Member Pays the Difference" differential.

***Your physician must substantiate the medical necessity for the Non-Preferred product vs the Preferred product(s) and the available generic altenrative(s) through CVS Caremark's formal appeals process

Anthem Blue Cross Smoking Cessation Benefits: PERS Care/Choice/Select offered up to a three-month supply of physician prescribed smoking cessation drugs annually (Member is responsible for co-payment). Discounts are available for items such as nicotine patches, gum, etc. through Anthem Blue Cross' discount over-the-counter drug program (Member pays the total cost of these items). The plan reimburses up to $100 per calendar year for counseling, behavior modification classes, or alternative treatments – such as biofeedback – for treatment of tobacco use, where network coverage applies with either 80/20 par coverage or non-par coverage applying. This applies in all 50 states.

Durable Medical Equipment bebefits: Rental or purchase of durable medical equipment, including one pair of custom molded and cast shoe inserts per calendar year, and outpatient prosthetic appliances, including one scalp hair prosthetic up to $350 per calendar year. Benefits for all durable medical equipment and prosthetic appliances, except cochlear implants and bone-anchored hearing aid, combined are limited to a maximum of $6,000 per calendar year.

IMPORTANT: Under PERS Select Plan, they have a tiered Narrow Hospital Network, with varying coinsurance. Tier One hospitals, which are those with the best-negotiated reimbursement rates, will have an 80 percent coinsurance coverage and $3000/$6000 (member/family) maximum out-of-pocket expense. Tier two hospitals will have reduced coinsurance coverage of 70 percent and have an increased maximum out-of-pocket expense of $6000/$12000 (member/family). The elective use of non-participating hospitals will remain at 60 percent coverage with NO maximum out-of-pocket application.

This document is intended to merely highlight or summarize certain aspects of the employer's benefit program(s). It is not a summary plan description (SPD) or an official plan document. Your rights and obligations under the program(s) are set forth in the official plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriate plan fiduciary. In the case of an ambiguity or outright conflict between a provision in this summary and a provision in the plan documents, the terms of the plan documents control. The employer reserves the right to review, change, or terminate the plan, or any benefits under it, for any reason, at any time and without advance notice to any person.