Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS PPO Plans 2012 Benefits					
Plan Provisions	EPO	PersCare		PersChoice		PersSelect (Sutter Excluded)	
Plan	In Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Plan Type	In Network Only	Open Ac	cess PPO	Open Access PPO		Select Network PPO	
,	\$350/ person	-	person	\$500/ person		\$500/ person	
Deductible (Calendar Year)	\$1,050/family	\$1,000/family		\$1,000/family		\$1,000/family	
Deductible Apply to OOP max?	No	No	No maximum	No	No maximum	No	No maximum
Out of Docket Mariner	\$1,000/person	\$2,000/person	No maximum	\$3,000/person	No maximum	\$3,000/person	No maximum
Out of Pocket Maximum	\$3,000/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
Office Visits - Primary Care	\$25 copay		40% after Deductible	\$20 copay	40% after Deductible		40% after Deductible
Office Visits - Specialists	\$30 copay	\$20 copay \$20 copay	40% after Deductible	\$20 copay	40% after Deductible	\$20 copay \$20 copay	40% after Deductible
Coinsurance You Pay	\$30 Copay 10%	10%	40% arter Deductible	20%	40% after Deductible	20%	40% after Deductible
Collisurance fou Pay	\$100 copay per	1070	4070	2070	4070	2070	4070
Hospital Copay	confinement	\$250 Deductible per confinement		\$0 copay per confinement		\$0 copay per confinement	
Trospital copay	commencia	Ψ230 Deddelible	per commement	φο εσράγ ρεί	Commenter	20%-30% after	Commenter
Hospital Coinsurance	10% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	Deductible	40% after Deductible
Outpatient Services	10% 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	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Preventative Care	\$0	\$0	40% after Deductible	\$0	40% after Deductible	\$0	40% after Deductible
Allergy Testing/Treatment	\$30 copay	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	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
DXL with Physician OV	\$25 copay	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Care	\$25 copay	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Chiropractic Maximum	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	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible

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Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS PPO Plans 2012 Benefits					
Plan Provisions	EPO	PersCare		PersChoice		PersSelect (Sutter Excluded)	
Plan	In Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Plan Type	In Network Only	Open Ac	cess PPO	Open Ac	cess PPO	Select Net	twork PPO
Acupuncture Maximum	30 Combined Chiro/Acupuncture Visits Per Year	20 Combined Chiro/Acu	puncture Visits Per Year	15 Combined Chiro/Acupuncture Visits Per Year		15 Combined Chiro/Acupuncture Visits Per Year	
Urgent Care	\$30 Copay	\$20 Copay	40% after Deductible	\$20 Copay	40% after Deductible	\$20 Copay	40% after Deductible
	\$100 Deductible (waived	<del>1</del> - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -		1-0 00 00/		1-0 00001	
Emergency Room	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	)%	20%		20%	
If Emergency Criteria Not Met	\$100 Deductible (waived if admitted)	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	\$250 Deductible, then 10%	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Outpatient	\$25 Copay	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	\$250 Deductible, then 10%	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Outpatient	\$25 Copay	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20%-30% after Deductible	40% after Deductible
Ambulance	10% after Deductible	20% after	Deductible	20% after	Deductible	20% after Deductible	
Home Health Care	10% 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	100 visit per	calendar year	45 visits per calendar year		45 visits per calendar year	
Hospice	10% after Deductible	10% after	Deductible	20% after	Deductible	20% after Deductible	
Hospice Care Lifetime Limit	\$10,000	No limit		No limit		No limit	
Occupational/Physical/Speech Therapy							
Inpatient	\$100 Copay, 10% after Deductible	No Charge		No Charge		No Charge	
Outpatient	\$30 Copay	20% after	Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Precertification Req.		No precert required		> 24 Visits		> 24 Visits	
Skilled Nursing Care							

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS PPO Plans 2012 Benefits						
Plan Provisions	EPO	PersCare		PersChoice		PersSelect (Sutter Excluded)		
Plan	In 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		Select Network PPO		
		10% 1st 10 days, 20% next 170 days, precert		20% 1st 10 days, 30% next 90 days, precert		20% 1st 10 days, 30% next 90 days, precert		
Innationt	\$100 Copay, 10% after	req, 180 days max per	40%, precert req, 180	req, 100 days max per	40%, precert req, 100	req, 100 days max per	40%, precert req, 100	
Inpatient	Deductible Not covered	year	days max per year	year	days max per year	year	days max per year	
Outpatient Vision Exam	Not covered  Not covered	Not co		Not covered  Not covered		Not co		
	\$25 Copay	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
Hearing Exam	50% after Deductible,	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
Hearing Aids	\$5,000 annual max	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
7.009	one device every 36	10 70 ditai Daddalbia	10 70 area Dedacable	2070 ditai Daddedbie	10 70 area Dedacable	2070 ditai Deddecibie	10 70 ditti Deddetible	
Hearing Aid Frequency	months	one device ev	evice every 36 months one device every 36 months		one device every 36 months			
Durable Medical Equipment	10% after Deductible	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible	
DME Precertification	None	> \$1	,000	> \$1	,000	> \$1	,000	
Prosthetic Device Limit	\$10,000	No limit		No limit		No limit		
Infertility Services	10% after Deductible	Not co	overed	Not covered		Not covered		
Prescription Drug								
Retail								
Generic	\$10 Copay/30 days	\$5 Copay	//30 days	\$5 Copay	\$5 Copay/30 days \$5 C		pay/30 days	
Brand Formulary	\$25 Copay/30 days	\$20 Copa	y/30 days	\$20 Copay/30 days		\$20 Copay/30 days		
Brand Non-Formulary	\$50 Copay/30 days	\$50 Copay/30 days		\$50 Copay/30 days		\$50 Copay/30 days		
Retail Maintenance			,		,		,	
Generic	\$10 Copay/30 days	\$10 Copay/30 days		\$10 Copay/30 days		\$10 Copay/30 days		
Brand Formulary	\$25 Copay/30 days	\$40 Copay/30 days		\$40 Copay/30 days		\$40 Copay/30 days		
Brand Non-Formulary	\$50 Copay/30 days	\$50 Copay/30 days		\$100 Copay/30 days		\$100 Copay/30 days		
Mail Order								
Generic	\$20 Copay/90 days	\$10 Copay/90 days	Not Available	\$10 Copay/90 days	Not Available	\$10 Copay/90 days	Not Available	
Brand	\$50 Copay/90 days	\$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	\$50 Copay/90 days	Not Available	\$100 Copay/90 days	Not Available	\$100 Copay/90 days	Not Available	
Rx Copy Maximum/person	\$1,000/year	\$1,000/year		\$1,000/year		\$1,000/year		

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Foothill De Anza Co	mmunity College District	CalPERS HMO Plans			
	ARY PLAN COMPARISONS		2012 Benefits		
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value	
Plan	In Network	In Network	In Network	In Network	
Plan Type	НМО	НМО	НМО	HMO	
	\$0/person	\$0/person	\$0/person	\$0/person	
Deductible (Calendar Year)	\$0/family	\$0/family	\$0/family	\$0/family	
Out of Docket Mariner	\$1,500/person	\$1,500/person	\$1,500/person	\$1,500/person	
Out of Pocket Maximum	\$3,000/family	\$3,000/family	\$3,000/family	\$3,000/family	
Lifetime Maximum Limit	No Limit	No Limit	No Limit	No Limit	
Office Visits - Primary Care	\$20 copay	\$15 copay	\$15 copay	\$15 copay	
Office Visits - Specialists	\$20 copay	\$30 copay	\$30 copay	\$30 copay	
			No, if in same physician	No, if in same physician	
Specialist Refferal Required?	Yes	Yes	med group	med group	
Coinsurance You Pay	0%	0%	0%	0%	
Hospital Copay	No Charge	No Charge	No C	harge	
Outpatient Services	\$20 Per Procedure	\$15 Per Procedure	\$0 - (\$250 copay for	specified procedures)	
Surgery/Anesthesia	\$20 Outpatient	\$15 Outpatient		harge	
Preventative Care	\$0	\$0	\$0	\$0	
Allergy Testing/Treatment	No Charge	\$15 testing		narge	
Diagnostic X-ray and Lab	Some Copays	Some Copays		narge	
DXL with Physician OV	\$0	\$0	\$0	\$0	
Chiropractic Care	\$15 copay	Not Covered		overed	
Chiropractic Maximum	30 Visits Per Year	Not Covered	Not Co	overed	
		\$15 copay when med			
Acupuncture Care	\$20 copay when med necessary	necessary		overed	
Acupuncture Maximum	None	None		overed	
Urgent Care	\$20 Copay	\$15 copay	\$15 copay	\$15 copay	
		\$50 Copay(waived if	\$50 Copay(waived if	\$50 Copay(waived if	
Emergency Room	\$50 Copay(waived if admitted)	admitted)	admitted)	admitted)	
Emergency Room Services	100%	100%	100%	100%	
If Emergency Criteria Not Met	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Mental Health					
Inpatient	No Charge	No Charge	No C	narge	
	Individ \$20 copay, Group - \$10				
Outpatient	copay	\$15 copay	\$15 copay	\$15 copay	
Substance Abuse					
Inpatient	No Charge	No Charge	No C	harge	
	Individ \$20 copay, Group - \$5				
Outpatient	copay	\$15 copay	\$15 copay	\$15 copay	
Ambulance	No Charge	No Charge		harge	
Home Health Care	No Charge	No Charge		harge	
Home Health Care Visit Limit	No Limit	No Limit	No Limit	No Limit	
Hospice	No Charge	No Charge		narge	
Hospice Care Lifetime Limit	No Limit	No Limit	No Limit	No Limit	
Occupational/Physical/Speech					
Therapy					
Inpatient	No Charge	No Charge	No C	harge	

Foothill De Anza Co	mmunity College District	CalPERS HMO Plans			
<b>JULY 1, 2010 SUMM</b>	ARY PLAN COMPARISONS	2012 Benefits			
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value	
Plan	In Network	In Network	In Network	In Network	
Plan Type	НМО	НМО	HMO	НМО	
Outpatient	\$20 Copay	\$15 copay	\$15 copay	\$15 copay	
Precertification Req.	Not Required	Not Required	Not Required	Not Required	
Skilled Nursing Care					
		No Charge - Up to 100			
Inpatient	No Charge - Up to 100 days	days	No Charge - L		
Outpatient	Not Covered	Not Covered	Not Co	overed	
Vision Exam	No Charge	No Charge	No C		
Hearing Exam	No Charge	No Charge		narge	
Hearing Aids	\$500	\$1,000	First \$1,000 covered		
Hearing Aid Frequency	Every 36 months	Every 36 months	Every 36 months	Every 36 months	
Durable Medical Equipment	No Charge	No Charge Not Required	No Charge		
DME Precertification	Precertification Not Required		Not Required	Not Required	
Prosthetic Device Limit	No Limit	No Limit	No Limit	No Limit	
	Services for diagnosis and treatment				
	of involuntary infertility and artificial				
Infertility Services	insemination only, no outpatient Rx	50% of allowed charges	50% of allow	able amount	
Prescription Drug	,				
Retail					
Generic	\$5 Copay/30 days	\$5 Copay/30 days	\$5 Copay/30 days	\$5 Copay/30 days	
Brand Formulary	\$10 Copay/30 days	\$20 Copay/30 days	\$20 Copay/30 days	\$20 Copay/30 days	
Brand Non-Formulary	N/A	N/A	\$50 Copay/30 days - 9	30 copay specialty Rx	
			Generic substitution pen	alties apply (\$5 plus cost	
Retail Maintenance			differ		
Generic	\$5 Copay/30 days	\$5 Copay/30 days	\$10 Copay/30 days	\$10 Copay/30 days	
Brand Formulary	\$10 Copay/30 days	\$20 Copay/30 days N/A	\$40 Copay/30 days	\$40 Copay/30 days	
Brand Non-Formulary			\$100 Copay/30 days	\$100 Copay/30 days	
Mail Order					
Generic	\$10 Copay/100 days	\$10 Copay/100 days	\$10 Copay/100 days	\$10 Copay/100 days	
Brand	\$20 Copay/100 days	\$40 Copay/100 days	\$40 Copay/100 days	\$40 Copay/100 days	
Brand Non-Formulary	N/A	N/A	\$100 Copay/100 days	\$100 Copay/100 days	
Rx Copay Maximum/person	No max	No max	\$1,000 per person	\$1,000 per person	
Out-of-Plan Coverage	Emergency Only	Emergency Only	Blue Card	Blue Card	

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