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	
Deductible (Calendar Year)	$350/ person	$500/ person		$500/ person		$500/ person	
	$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 Pocket Maximum	$1,000/person	$2,000/person	No maximum	$3,000/person	No maximum	$3,000/person	No 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	$20 copay	40% after Deductible	$20 copay	40% after Deductible	$20 copay	40% after Deductible
Office Visits - Specialists	$30 copay	$20 copay	40% after Deductible	$20 copay	40% after Deductible	$20 copay	40% after Deductible
Coinsurance You Pay	10%	10%	40%	20%	40%	20%	40%
Hospital Copay	$100 copay per confinement	$250 Deductible per confinement		$0 copay per confinement		$0 copay per confinement	
Hospital Coinsurance	10% 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	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

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	
Acupuncture 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	
Urgent Care	$30 Copay	$20 Copay	40% after Deductible	$20 Copay	40% after Deductible	$20 Copay	40% after Deductible
Emergency Room	$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%		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	
Inpatient	$100 Copay, 10% 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
Outpatient	Not covered	Not covered		Not covered		Not covered	
Vision Exam	Not covered	Not covered		Not covered		Not covered	
Hearing Exam	$25 Copay	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	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	
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 covered		Not covered		Not covered	
Prescription Drug							
Retail							
Generic	$10 Copay/30 days	$5 Copay/30 days		$5 Copay/30 days		$5 Copay/30 days	
Brand Formulary	$25 Copay/30 days	$20 Copay/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	

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS HMO Plans 2012 Benefits		
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value
Plan	In Network	In Network	In Network	In Network
Plan Type	HMO	HMO	HMO	HMO
Deductible (Calendar Year)	$0/person	$0/person	$0/person	$0/person
	$0/family	$0/family	$0/family	$0/family
Out of Pocket Maximum	$1,500/person	$1,500/person	$1,500/person	$1,500/person
	$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
Specialist Refferal Required?	Yes	Yes	No, if in same physician med group	No, if in same physician med group
Coinsurance You Pay	0%	0%	0%	0%
Hospital Copay	No Charge	No Charge	No Charge	
Outpatient Services	$20 Per Procedure	$15 Per Procedure	$0 - ($250 copay for specified procedures)	
Surgery/Anesthesia	$20 Outpatient	$15 Outpatient	No Charge	
Preventative Care	$0	$0	$0	$0
Allergy Testing/Treatment	No Charge	$15 testing	No Charge	
Diagnostic X-ray and Lab	Some Copays	Some Copays	No Charge	
DXL with Physician OV	$0	$0	$0	$0
Chiropractic Care	$15 copay	Not Covered	Not Covered	
Chiropractic Maximum	30 Visits Per Year	Not Covered	Not Covered	
Acupuncture Care	$20 copay when med necessary	$15 copay when med necessary	Not Covered	
Acupuncture Maximum	None	None	Not Covered	
Urgent Care	$20 Copay	$15 copay	$15 copay	$15 copay
Emergency Room	$50 Copay(waived if admitted)	$50 Copay(waived if admitted)	$50 Copay(waived if admitted)	$50 Copay(waived if 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 Charge	
Outpatient	Individ. - $20 copay, Group - $10 copay	$15 copay	$15 copay	$15 copay
Substance Abuse				
Inpatient	No Charge	No Charge	No Charge	
Outpatient	Individ. - $20 copay, Group - $5 copay	$15 copay	$15 copay	$15 copay
Ambulance	No Charge	No Charge	No Charge	
Home Health Care	No Charge	No Charge	No Charge	
Home Health Care Visit Limit	No Limit	No Limit	No Limit	No Limit
Hospice	No Charge	No Charge	No Charge	
Hospice Care Lifetime Limit	No Limit	No Limit	No Limit	No Limit
Occupational/Physical/Speech Therapy				
Inpatient	No Charge	No Charge	No Charge	

Foothill De Anza Community College District JULY 1, 2010 SUMMARY PLAN COMPARISONS		CalPERS HMO Plans 2012 Benefits		
Plan Provisions	Kaiser	Kaiser	Blue Shield Access+	Blue Shield Net Value
Plan	In Network	In Network	In Network	In Network
Plan Type	HMO	HMO	HMO	HMO
Outpatient	$20 Copay	$15 copay	$15 copay	$15 copay
Precertification Req.	Not Required	Not Required	Not Required	Not Required
Skilled Nursing Care				
Inpatient	No Charge - Up to 100 days	No Charge - Up to 100 days	No Charge - Up to 100 days	
Outpatient	Not Covered	Not Covered	Not Covered	
Vision Exam	No Charge	No Charge	No Charge	
Hearing Exam	No Charge	No Charge	No Charge	
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	No Charge	
DME Precertification	Not Required	Not Required	Not Required	Not Required
Prosthetic Device Limit	No Limit	No Limit	No Limit	No Limit
Infertility Services	Services for diagnosis and treatment of involuntary infertility and artificial insemination only, no outpatient Rx	50% of allowed charges	50% of allowable 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 - $30 copay specialty Rx	
Retail Maintenance			Generic substitution penalties apply ($5 plus cost difference)	
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	$40 Copay/30 days	$40 Copay/30 days
Brand Non-Formulary	N/A	N/A	$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