Compare for yourself. Choose CCPOA Medical.

CCPOA Medical Plan – Coverage Comparison Highlights			
Category	**CCPOA Medical**	**Kaiser**	**PERS Select (PPO)**
Calendar Year Deductible	**None**	None	$500
HOSPITAL			
Inpatient (includes blood and blood products - collection and storage of autologous blood)	$100 per admission	$0.00	20–30% (hospital tiers)
Outpatient Facility / Surgery Services	$50	$15	20–30% (hospital tiers)
Emergency Care/Services	$75 (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50 (co-pay waived if admitted as an inpatient or for observation as an outpatient)	20% (applies to other services such as physician, x-ray, lab, etc.)
PHYSICIAN SERVICES			
Office Visits	$15/visit	$15/visit	$20/visit
Inpatient Visits	**No Charge**	No Charge	20%
Outpatient Visits	$15/visit	$15/visit	$20/visit
Urgent Care Visits	$15/visit	$15/visit	$20/visit
Surgery / Anesthesia	**No Charge**	No Charge	20%
Diagnostic X-ray/Lab	**No Charge**	No Charge	20%
Durable Medical Equipment (including orthoses and prostheses)	**No Charge**	No Charge	20%
Physical / Occupational / Speech Therapy	**No Charge**	$15/visit	20%
Skilled Nursing Facility Medicare (up to 100 days/benefit period)	**No Charge**	No Charge	No Charge
Hospice (Medicare)	**No Charge**	No Charge	No Charge
PRESCRIPTIONS			
Prescription Drug Deductible	Brand Formulary: $50 (not to exceed $150/family)	N/A	N/A
Prescription Drugs Obtained at a Pharmacy *(not to exceed 30-day supply)*	Generic: $10 Brand Formulary: $25 Non-Formulary: $50	Generic: $5 Brand: $20	Generic: $5 Preferred: $20 Non-Preferred: $50
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $20 Brand Formulary: $50 Non-Formulary:$100	Generic: $10 Brand: $40 *(31–100 day supply)*	Generic: $10 Preferred: $40 Non-Preferred: $100
MENTAL HEALTH			
Inpatient	$100 per admission	No Charge	20%
Outpatient	$15/visit	$15	20%
CHIROPRACTIC SERVICES			
Chiropractic Examination up to 20 visits per calendar year	**$15/visit**	$15/visit	$15/visit
MEMBER'S MAXIMUM CALENDAR YEAR COPAYMENT			
Maximum Calendar Year Co-pay (excluding pharmacy) *(See each plan's EOC for other items not counted toward co-pay max limit)*	$1,500 per Member $4,500 per Family	$1,500 per Member $3,000 per Family	$3,000 (co- insurance) $4,000 per Family

Values shown are from best information at printing time, and are for comparison only. Rates and coverage are subject to change.
The Benefit Trust Fund does not set or control coverage by other carriers or agencies. 2018 Evidence of Coverage documents (when released) can be found at the CalPERS website.