Santa Monica College
Comparison of PERSCare and PERS Choice for SMCFA-SMCCD Art. 10.2

Non-Medicare Coverage

2018 Plan Year

Deductibles Copayment/Coinsurane	PERS*Care* Member Pays		PERS*Choice* Member Pays	
Calendar Year Deductibles	$500	Member	$500	Member
	$1,000	Family	$1,000	Family
Maximum Calendar Year Copayment/Coinsurance Responsibility	$2,000	Member	$3,000	Member
	$4,000	Family	$6,000	Family
Hospital Admission Deductible	$250 Per admission		No Charge	
Emergency Room Deductible	$50 Per visit		$50 Per visit	

For 2018, the following categories ARE eligible for reimbursement per 10.2.1 of the District-FA Agreement:

Check Box for each type of reimbursement applied	Benefits	PERSCare Member Pays			PERS *Choice* Member Pays			Eligible for Reimbursement (Based on PPO charges)
		PPO	Non-PPO	Comments	PPO	Non-PPO	Comments	
☐	**Home Health Care**	10%	40%	Skilled care, NOT custodial care, up to **100 visits** per calendar year.	20%	40%	Skilled care, NOT custodial care, up to **45 visits** per calendar year.	**46-100 visits 90%**
☐	**Occupational Therapy**	10%	10%	Limited to a combined total of **24 visits** per calendar year for physicial and occupational therapy	20%	20%	Limited to a combined total of **24 visits** per calendar year for physicial and occupational therapy	**10%**
☐	**Physical Therapy**	10%	40%	Limited to a combined total of **24 visits** per calendar year for physicial and occupational therapy	20%	40%	Limited to a combined total of **24 visits** per calendar year for physicial and occupational therapy	**10%**
☐	**Skilled Nursing Care and Rehabilitation Care**			Up to **180 days** per calendar year.			Up to **100 days** per calendar year.	**Days 101-180 80%**
	Medically necessary skilled care, NOT custodial care, in a skilled nursing facility.	10%	40%	Days 1-10	20%	40%	Days 1-10	
		20%	40%	Days 11-180	30%	40%	Days 11-100	

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Benefits	PERS*Care* Member Pays			PERS *Choice* Member Pays		
	PPO	Non-PPO	Comments	PPO	Non-PPO	Comments
Ambulance	10%	10%	Air and ground ambulance services	20%	20%	Air and ground ambulance services
Ambulatory Surgery Center (Services in connection with outpatient surgery)	10%	40%	Maximum plan payment $350 applies to facility charges from a non-PPO provider	20%	40%	Maximum plan payment $350 applies to facility charges from a non-PPO provider
Arthroscopy Services	10%	40%	Maximum plan payment of $6000 applies to Outpatient Hosptial Setting	20%	40%	Maximum plan payment of $6000 applies to Outpatient Hosptial Setting
Autism Spectrum Disorder	$20	40%	Outpatient Care	$20	40%	Oupatient Care
Bariatric Surgery	10%	10%	For non-California residents an additional $250 copay applies-see Plan Guide	20%	20%	For non-California residents an additional $250 copay applies-see Plan Guide
Cardiac Care	10%	40%	Hospital & professional services provided in connection with cardiac care	20%	40%	Hospital & professional services provided in connection with cardiac care
Cataract Surgery	10%	40%	Maximum plan payment of $2000 applies to Outpatient Hosptial Setting	20%	40%	Maximum plan payment of $2000 applies to Outpatient Hosptial Setting
Chiropractic & Acupuncture	$15	40%	Max **20 visits** per calendar year for any combination of chiropractic/acupuncture	$15	40%	Max **20 visits** per calendar year for any combination of chiropractic/acupuncture
Christian Science Treatment	10%	10%	Outpatient treatment for a covered illness or injury when services are provided by Christian Science nurse, Christian Science nursing facility, or Christian practitioner.	20%	20%	Outpatient treatment for a covered illness or injury when services are provided by Christian Science nurse, Christian Science nursing facility, or Christian practitioner.
Cleft Palate	10%	40%	Medically necessary dental or orthodontic services that are an integral part of recontructive surgery for cleft palate.	20%	40%	Medically necessary dental or orthodontic services that are an integral part of recontructive surgery for cleft palate.
Clinical Trials	10%	40%	Routine patient costs for an approved clinical trial.	20%	40%	Routine patient costs for an approved clinical trial.
Colonoscopy Services	0% Preventative 10% Diagnostic	40%	Maximum plan payment of $1500 applies to Outpatient Hosptial Setting	0% Preventative 20% Diagnostic	40%	Maximum plan payment of $1500 applies to Outpatient Hosptial Setting
Diagnostic X-Ray/Laboratory	10%	40%	Outpatient diagnostic X-ray & lab services including Pap tests and mamograms for treatment of illness.	20%	40%	Outpatient diagnostic X-ray & lab services including Pap tests and mamograms for treatment of illness.

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Benefits	PERS*Care* Member Pays			PERS *Choice* Member Pays		
	PPO	Non-PPO	Comments	PPO	Non-PPO	Comments
Durable Medical Equipment	10%	40%	Rental or purchase of durable medical equipment, including one pair of custom molded and cast shoe inserts per calendar year, and outpatient prostthetic appliances, including one scalp hair prosthetic up to $350 per calendar year.	20%	40%	Rental or purchase of durable medical equipment, including one pair of custom molded and cast shoe inserts per calendar year, and outpatient prostthetic appliances, including one scalp hair prosthetic up to $350 per calendar year.
Emergency Care Services	10%	10%	$50 emergency room deductible applies unlesss admitted to hospital; if admitted to hospital, the $50 ER ded. Is waived and the $250 hospital admission deductible applies	20%	20%	$50 emergency room deductible applies unlesss admitted to hospital; if admitted to hospital, the $50 ER deductible is waived
Family Planning	10%	40%	Voluntary sterilization and medically necessary abortions	20%	40%	Voluntary sterilization and medically necessary abortions
Hearing Aid Services	10%	40%	Up to one hearing aid every 36 months	20%	40%	Up to one hearing aid every 36 months
Hip and Knee Joint Replacement Surgery	10%	40%	Limited to $30,000 per procedure	20%	40%	Limited to $30,000 per procedure
Home infusion Therapy	10%	40%	Skilled nursing visits	20%	40%	Skilled nursing visits
Hospice Care	10%	10%	Palliative Treatment of pain and other symptoms associated with terminal disease.	20%	20%	Palliative Treatment of pain and other symptoms associated with terminal disease.
Hospital (Inpatient)	10%	40%	Room & Board, general nursing care, operating and special care room fees; diagnostic X-ray and laboratory servcies	20%	40%	Room & Board, general nursing care, operating and special care room fees; diagnostic X-ray and laboratory servcies
Hospital (Outpatient)	10%	40%	Diagnostic, theraeutic and surgical services including radiation therapy, chemo, and kidney dialysis Colonoscopy - Limited to $1,500 per procedure Cataract Surgery - Limited to $2,000 per procedure Arthroscopy - Limited to $6,000 per procedure	20%	40%	Diagnostic, theraeutic and surgical services including radiation therapy, chemo, and kidney dialysis Colonoscopy - Limited to $1,500 per procedure Cataract Surgery - Limited to $2,000 per procedure Arthroscopy - Limited to $6,000 per procedure
Maternity Care	10%	40%	Prenatal/postnatal; deliveries, hospitalization and newborn nursery care; $250 ded applies for each admission	20%	40%	Prenatal/postnatal; deliveries, hospitalization and newborn nursery care

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Benefits	PERS*Care* Member Pays			PERS *Choice* Member Pays		
	PPO	Non-PPO	Comments	PPO	Non-PPO	Comments
Mental Health (Inpatient)	10%	40%	Hospital/physician services to stabalize an acute psychiatric condition	20%	40%	Hospital/physician services to stabalize an acute psychiatric condition
Mental Health (Outpatient)	10%	40%	Hospital/physician services to stabalize an acute psychiatric condition Facility-based care	20%	40%	Hospital/physician services to stabalize an acute psychiatric condition Facility-based care
	$20	40%	Physician Office Visits	$20	40%	Physician Office Visits
Natural Childbirth Classes	50%	50%	Plan pays 50% of registration fee up to $50, whichever is less	50%	50%	Plan pays 50% of registration fee up to $50, whichever is less
Outpatient Cardiac Rehabilitation	10%	40%	Up to 40 visits per calendar year	20%	40%	Up to 40 visits per calendar year
Outpatient Pulmonary Rehabilitation	10%	40%	Up to 30 visits per calendar year	20%	40%	Up to 30 visits per calendar year
Physician Services	$20	40%	Office visits, outpatient hospital and outpatient urgent care visits.	$20	40%	Office visits, outpatient hospital and outpatient urgent care visits.
	10%	40%	Other services, including affiliated facility charges	20%	40%	Other services, including affiliated facility charges
Preventive Care	0%	40%	No copayment for PPO Provider	0%	40%	No copayment for PPO Provider
Reconstructive Surgery	10%	40%	Hospital/physician services in connection with reconstructive surgery	20%	40%	Hospital/physician services in connection with reconstructive surgery
Retail Health Clinic	$20	40%	Basic medical services ans supplies provided by physician assistants and/or nurse practitioners during an office visit.	$20	40%	Basic medical services ans supplies provided by physician assistants and/or nurse practitioners during an office visit.
	10%	40%	Other services, including affiliated facility charges	20%	40%	Other services, including affiliated facility charges
Smoking Cessation Program	0%	0%	Plan pays 100% of program fee up to $100 per calendar year	0%	0%	Plan pays 100% of program fee up to $100 per calendar year
Speech Therapy	10%	40%	Up to 24 visits per calendar year	20%	40%	Up to 24 visits per calendar year
Substance Abuse	10%	40%	Inpatient - Hospital/physician services for short-term medical management of detoxification or withdrawal symptoms; $250 hospital admission deductible applies for each admission.	20%	40%	Inpatient - Hospital/physician services for short-term medical management of detoxification or withdrawal symptoms
	10%	40%	Outpatient - Facility-based care for medically necessary treatment to stabilize an acute substance abuse condition	20%	40%	Outpatient - Facility-based care for medically necessary treatment to stabilize an acute substance abuse condition
	$20	40%	Physician office visits	$20	40%	Physician office visits
Telemedicine Program	$20 + 10%	$20 + 10%	Services provided by a Telemedicine Network Presentation Site or Specialty Center	$20 + 20%	$20 + 20%	Services provided by a Telemedicine Network Presentation Site or Specialty Center
Transgender Surgery	20%	40%	Inpatient or outpatient facility-based care	20%	40%	Inpatient or outpatient facility-based care
	$20	40%	Physician Office Visits	$20	40%	Physician Office Visits

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Benefits	PERS*Care* Member Pays			PERS *Choice* Member Pays		
	PPO	Non-PPO	Comments	PPO	Non-PPO	Comments
Transplant Benefits	10%	40%	Cornea and Skin	20%	40%	Cornea and Skin
	10%	10%	Special Transplants	20%	20%	Special Transplants
Urgent Care	$20	40%	Office visit	$20	40%	Office visit
	10%	40%	Other physician services, such as lab work or sutures	20%	40%	Other physician services, such as lab work or sutures