# **PERS** *Platinum*

**Understanding your costs**

As a CalPERS member enrolled in the PERS Platinum plan with Blue Shield of California, it's helpful to know what your costs will be when seeing a provider or having a procedure. We've put together this quick guide to help show your share of costs for services and explain some key healthcare terms. For more details, please see your *Evidence of Coverage* (EOC) or call Included Health at **(855) 633-4436 (TTY: 711)**, 24 hours a day, seven days a week.

## PERS Platinum cost shares at a glance

| | In network | Out of network |
|---|---|---|
| **Calendar-year deductible** | Individual $500<br>Family $1,000 | Individual $2,000<br>Family $4,000 |
| **Calendar-year coinsurance maximum** | Individual $2,000<br>Family $4,000 | Does not apply |
| **Calendar-year out-of-pocket maximum (medical)*** | Individual $7,200<br>Family $14,400 | Does not apply |
| | **Member copay ($) and coinsurance (%)** | |
| **Hospital visit (inpatient or outpatient)†** | $250 + 10% | $250 + 40% |
| **Emergency room visit** | $50 + 10% | $50 + 40% |
| **Primary care physician (PCP) office visit‡** | $20 | 40% |
| **Specialist or other doctor office visit‡** | $35 | 40% |
| **Urgent care center visit‡** | $35 | 40% |

* Three categories count toward your in-network out-of-pocket maximum throughout the year: deductible, coinsurance, and copays.

† The $250 copay only applies to inpatient hospital admission. Inpatient services require an overnight stay in an inpatient facility. Outpatient services do not require an overnight stay and can vary in location.

‡ Deductible does not apply unless additional services are received during the visit. This means that this service is covered at the copay amount shown even if the deductible hasn't been met. Also, the copay amount you pay does not count toward your deductible. See your EOC for a list of covered services where the deductible does not apply.

For definitions of common healthcare cost terms, see page 3.

# Example: PERS Platinum cost breakdown (individual)*

**Deductible:** $500 | **Coinsurance:** 10% | **Coinsurance max:** $2,000 | **Out-of-pocket max:** $7,200

**January 1**

Jane pays a copay for office visits: $20 for matched PCP, $35 for other doctor or specialist. Her deductible does not apply.

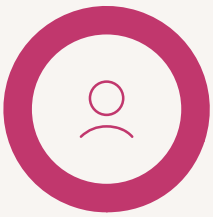
| | |
|---|---|
| **Deductible:** | $500 |
| (does not apply to office visits) | |
| PCP visit allowed amount: | $125 |
| Jane pays copay: | $20 |
| Plan pays: | $105 |

Jane is admitted to an in-network hospital for an inpatient stay. She is responsible for the $250 inpatient copay and her $500 individual deductible. After that, she pays 10% of the allowed amount for services from in-network providers, and the plan pays 90%. She pays her 10% until reaching $2,000, her coinsurance maximum.

| | |
|---|---|
| **Deductible:** | $500 |
| **Inpatient copay:** | $250 |
| **In-network coinsurance:** | 10% |
| Allowed amount: | $2,000 |
| Jane pays deductible: | $500 |
| and inpatient copay: | $250 |
| Jane pays 10% of balance: | $125 |
| Plan pays 90% of balance: | $1,125 |

**December 31**

Once Jane has met her deductible of $500 and her maximum coinsurance of $2,000 for the calendar year, the plan will pay 100% of in-network services where coinsurance applies. Jane will still pay plan copays.



| | |
|---|---|
| **Deductible:** | Met |
| **Coinsurance max:** | Met |
| Allowed amount: | $1,000 |
| Jane pays 0%: | $0 |
| Plan pays 100%: | $1,000 |
| PCP visit copay: | $20 |
| Specialist visit copay: | $35 |

Plan pays  Jane pays

If Jane reaches her $7,200 out-of-pocket maximum from in-network copays, deductible, and coinsurance paid through the plan year, then her plan will pay the full cost of her covered in-network healthcare services, including copays, for the rest of the calendar year.

*This is an example only. Specific amounts and situations will vary.
For definitions of common healthcare cost terms, see page 3.

# Definitions of common healthcare cost terms for PERS Platinum[1]

**Allowed amount**
The most you will pay for covered healthcare services when you see an in-network provider. It can also be called "eligible expense," "payment allowance," or "negotiated rate." If you use an out-of-network provider that charges more than the allowed amount, you will have to pay the difference. (See balance billing.)

**Balance billing**
When an out-of-network provider bills you for the difference between their rate and the allowed amount. For example, if the provider charges $100 and the allowed amount is $70, the provider may bill you for the remaining $30.

**Copayment (copay)**
A fixed amount that you pay for a covered healthcare service. For example, if you have a sore throat and see your PCP, you'll likely need to pay $20 for the visit. The amount can vary by the type of service.

**In-network provider**
**(also called "preferred provider")**
A provider (includes doctors, hospitals, urgent care centers, etc.) that has agreed to contract with Blue Shield to provide services. Seeing in-network providers can keep your costs down.

**Deductible**
This is the amount you owe for covered healthcare services before your plan begins to pay.* For example, if your deductible is $500, you pay the full cost of services up to that amount. Once you've paid $500, your plan will start paying for services.

*** Please note:** The PERS Platinum deductible does not apply to doctor or urgent care visits. This means you'll only have to pay the copay/coinsurance amount even if the deductible hasn't been met. Also, the copay/coinsurance amount you pay does not count toward your deductible. See the EOC for services that do not apply to the deductible.

**Coinsurance**
This is the percentage of the cost you will pay for covered healthcare services. For example, if a doctor's allowed amount is $100 for a service and your coinsurance is 10%, you'll pay $10 and your health plan will pay $90.

- In-network coinsurance is the percentage you pay when you use an in-network provider. It is usually less than out-of-network coinsurance.
- Out-of-network coinsurance is the percentage you pay when you use a provider that does not contract with your health plan. Out-of-network coinsurance costs you more than in-network coinsurance.

**Calendar-year coinsurance maximum**
This is the most you will pay in a year in coinsurance for covered in-network services. After you have spent this amount in coinsurance costs, your plan will pay 100% of the covered in-network services where coinsurance applies, and you'll pay no coinsurance for the rest of the year. You'll continue to pay plan copays. For PERS Platinum, the coinsurance maximum for covered services from in-network providers is $2,000 per individual or $4,000 per family per calendar year.

**Calendar-year out-of-pocket maximum**
This is the most you will pay in a year for covered services from in-network providers. This maximum is reached by adding what you've spent on your deductible, coinsurance, and copays. Once you've spent this amount, your health plan will pay 100% of the allowed amount for covered in-network services for the rest of the year and you won't have copays.

For 2025, the out-of-pocket maximum for medical expenses is $7,200 per individual or $14,400 per family.

For questions, please go to **includedhealth.com/calpers**.

1 If there are discrepancies between this information and the EOC, defer to the EOC.

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