

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 Family \$1,000	Individual \$2,000 Family \$4,000
	Calendar-year coinsurance maximum	Individual \$2,000 Family \$4,000	Does not apply
	Calendar-year out-of-pocket maximum (medical)*	Individual \$8,150 Family \$16,300	Does not apply
		Member copay (\$) and coinsurance (%)	
	Hospital visit (inpatient or outpatient)†	\$250 + 10%	\$250 + 40%
	Emergency room visit	\$50 + 10%	\$50 + 10%
	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.

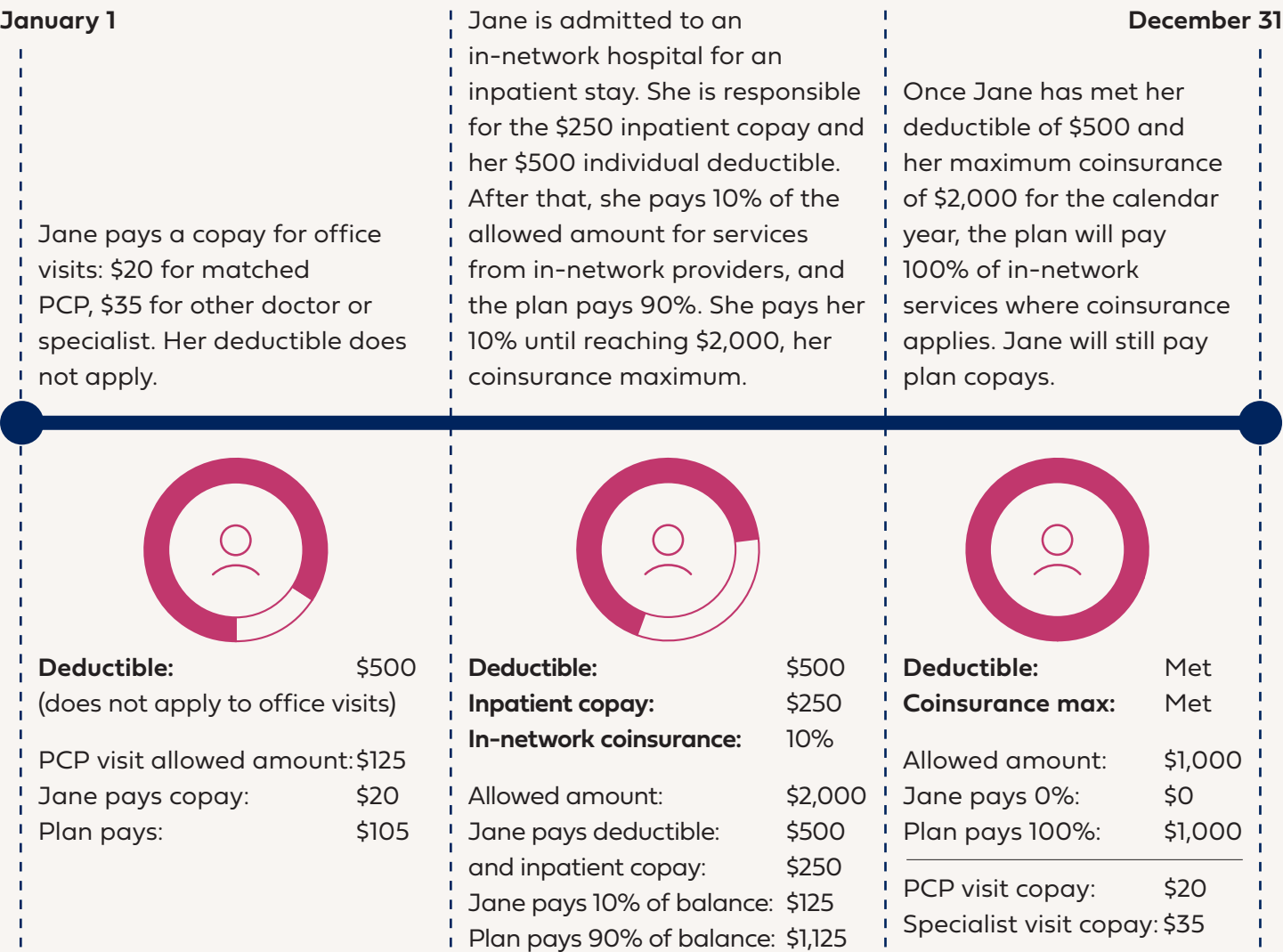
† The \$250 copay only applies to inpatient hospital admission. Inpatient services require an overnight stay in an inpatient facility. Outpatient services do not require an overnight stay and can vary in location.

‡ 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: \$8,150



 Plan pays  Jane pays

If Jane reaches her \$8,150 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 Platinum¹

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 coinsurance for covered in-network services in a year. Once you reach this amount for coinsurance costs, your plan will pay 100% of covered in-network services that usually require coinsurance, and you’ll pay no coinsurance for the rest of the year. You’ll continue to pay copays. For PERS Platinum, the coinsurance maximum 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 2026, the out-of-pocket maximum for medical expenses is \$8,150 per individual or \$16,300 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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