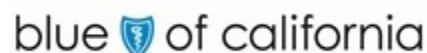


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Coverage Period: 1/1/2027 - 12/31/2027

Public Employees Benefit Retirement System (CalPERS) PERS Platinum Basic PPO Plan

Coverage for: Individual + Family | Plan Type: PPO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit includedhealth.com/calpers or call 1-855-633-4436. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 per individual / \$1,000 per family for <u>Preferred Providers</u> ; \$2,000 per individual / \$4,000 per family for <u>non-preferred providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription Drugs</u> , <u>Preventive care</u> , Primary Care visit, and <u>Specialist</u> visit for <u>Preferred Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 per individual / \$4,000 per family for <u>Preferred Providers</u> ; None per individual / None per family for <u>Non-Preferred Providers</u> . This <u>plan</u> has a separate Out of Pocket Maximum for <u>Prescription Drugs</u> of \$2,000 per individual / \$4,000 per family / \$1,000 Home Delivery.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. However, these expenses do count toward the maximum medical responsibility amount. The maximum medical responsibility (\$10,000 per Member and \$20,000 per family), in general, is accumulated by the Calendar Year Deductible, Coinsurance, and Copayments, for services provided by Preferred Providers.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, deductible and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See includedhealth.com/calpers or call 1-855-633-4436 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/visit; deductible does not apply	40% coinsurance	-----None-----
	Specialist visit	\$35/visit; deductible does not apply	40% coinsurance	
	Preventive care/screening /immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path: 10% coinsurance X-Ray & Imaging: 10% coinsurance Other Diagnostic Examination: 10% coinsurance	Lab & Path: 40% coinsurance X-Ray & Imaging: 40% coinsurance Other Diagnostic Examination: 40% coinsurance	Services received at Quest Diagnostic and Labcorp Facilities are paid at 100% for in-network providers. If you must travel more than 15 miles outside your services area to one of these two providers, a Laboratory Location Exception form is available.
	Imaging (CT/PET scans, MRIs)	Outpatient Radiology Center: 10% coinsurance Outpatient Hospital: 10% coinsurance	Outpatient Radiology Center: 40% coinsurance Outpatient Hospital: 40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition	Tier 1	\$5/30-day supply \$10/90-day supply	Not Covered	Your Prescription Drug Coverage is covered by CVS Caremark. For more information, please call 1-833-291-3649. A 90-day supply can be obtained via home delivery or at an in-network retail pharmacy.
	Tier 2	\$20/30-day supply \$40/90-day supply	Not Covered	
	Tier 3	\$50/30-day supply \$100/90-day supply	Not Covered	
	Specialty Pharmacy	Specialty follows the tier structure above.	Not Covered	Certain Specialty Medications are available only through the CVS Caremark Specialty Pharmacy and are limited up to a 30-day supply.

* For more information about limitations and exceptions, see the plan or policy document at includedhealth.com/calpers.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center: 10% coinsurance Outpatient Hospital: 10% coinsurance	Ambulatory Surgery Center: 40% coinsurance subject to a benefit maximum of \$350/day Outpatient Hospital: 40% coinsurance	-----None-----
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	Facility Fee: \$50/visit + 10% coinsurance (waived if admitted) Physician Fee: 10% coinsurance	Facility Fee: \$50/visit + 10% coinsurance (waived if admitted) Physician Fee: 10% coinsurance	-----None-----
	Emergency medical transportation	10% coinsurance	10% coinsurance	This payment is for emergency or authorized transport.
	Urgent care	\$35/visit; deductible does not apply	40% coinsurance	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250/admission + 10% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20/visit; deductible does not apply Other Outpatient Services: 10% coinsurance Partial Hospitalization: 10% coinsurance Neuropsychological and Psychological Testing: 10% coinsurance	Office Visit: 40% coinsurance Other Outpatient Services: 40% coinsurance Partial Hospitalization: 40% coinsurance Neuropsychological and Psychological Testing: 40% coinsurance	Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.

* For more information about limitations and exceptions, see the plan or policy document at includedhealth.com/calpers.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Inpatient services	<i>Physician Inpatient Services:</i> 10% coinsurance <i>Hospital Services:</i> \$250/admission + 10% coinsurance <i>Residential Care:</i> \$250/admission + 10% coinsurance	<i>Physician Inpatient Services:</i> 40% coinsurance <i>Hospital Services:</i> 40% coinsurance <i>Residential Care:</i> 40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	-----None-----
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	\$250/admission + 10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per Calendar Year.
	Rehabilitation services	<i>Office Visit:</i> 10% coinsurance <i>Outpatient Hospital:</i> 10% coinsurance	<i>Office Visit:</i> 40% coinsurance <i>Outpatient Hospital:</i> 40% coinsurance	-----None-----
	Habilitation services	<i>Office Visit:</i> 10% coinsurance <i>Outpatient Hospital:</i> 10% coinsurance	<i>Office Visit:</i> 40% coinsurance <i>Outpatient Hospital:</i> 40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at includedhealth.com/calpers.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Skilled nursing care	Freestanding SNF: 10% coinsurance for the first 10 days; 20% coinsurance thereafter Hospital-based SNF: 10% coinsurance for the first 10 days; 20% coinsurance thereafter	Freestanding SNF: 40% coinsurance Hospital-based SNF: 40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 170 days per member per benefit period.
	Durable medical equipment	10% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	10% coinsurance	10% coinsurance	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | | |
|-----------------------|---|----------------------------|------------------------|
| • Cosmetic surgery | • Long-term care | • Private-duty nursing | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S | • Routine eye care (Adult) | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | | |
|---------------------|---------------------|----------------|-------------------------|
| • Acupuncture | • Chiropractic Care | • Hearing Aids | • Infertility Treatment |
| • Bariatric surgery | | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see the plan or policy document at includedhealth.com/calpers.

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice or assistance, contact: Included Health Customer Service at 1-855-633-4436 or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or dol.gov/ebsa/healthreform.

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助, 请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowól nínízingo, kwijí' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਵਿਰਾਮ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ອຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ 1-866-346-7198.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of [preferred](#) pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copay + coins	\$250+10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$2,100

Managing Joe's Type 2 Diabetes

(a year of routine [preferred](#) care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copay + coins	\$250+10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,200

Mia's Simple Fracture

([preferred](#) emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copay + coins	\$250+10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$20
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$700

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California provides:

- Aids and services at no cost to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services at no cost to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)

Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.