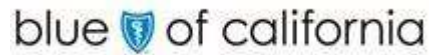


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



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

CalPERS EPO

Coverage for: Individual + Family | Plan Type: EPO



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 www.blueshieldca.com/calpers or call 1-800-334-5847. 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 deductible ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive care and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	<i>Medical: \$1,500 per individual / \$3,000 per family.</i> <i>Pharmacy: \$10,500 per individual / \$21,000 per family. Includes \$1,000 for mail-service formulary prescription drugs per member.</i>	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.blueshieldca.com/calpers or call 1-800-334-5847 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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
		Plan Provider (You will pay the least)	Non-Plan 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	\$15/visit	Not Covered	-----None-----
	Specialist visit	\$15/visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	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: No Charge X-Ray & Imaging: No Charge Other Diagnostic Examination: No Charge	Lab: Not Covered X-Ray & Imaging: Not Covered Other Diagnostic Examination: Not Covered	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	Outpatient Radiology Center: No Charge Outpatient Hospital: No Charge	Outpatient Radiology Center: Not Covered Outpatient Hospital: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://myoptions.blueshieldca.com/calpers/pharmacy .	Tier 1	Retail: \$5/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$10/prescription Home Delivery: \$10/prescription	Not Covered	Retail: Covers up to a 30-day supply; 50% coinsurance of Blue Shield contracted rate for drugs to treat erectile dysfunction. 90-days may be covered with a copayment for each 30-day supply.
	Tier 2	Retail: \$20/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$40/prescription Home Delivery: \$40/prescription	Not Covered	Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: Covers up to a 90-day supply. A list of select retail pharmacies can be obtained by going to the Pharmacy Resources page .

*For more information about limitations and exceptions, see the [plan](#) or policy document at www.blueshieldca.com/calpers.

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PENDING REGULATORY APPROVAL

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most)	
	Tier 3	Retail: \$50/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$100/prescription Home Delivery: \$100/prescription	Not Covered	Home Delivery: Covers up to a 90-day supply. Failure to obtain preauthorization may result in denial of coverage. Select Tier 2 and Tier 3 drugs require preauthorization .
	Tier 4	Retail: \$30/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$60/prescription Home Delivery: \$60/prescription	Not Covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by Network Specialty Pharmacies unless medically necessary for a covered emergency. Preauthorization is required. Failure to obtain preauthorization may result non-payment of benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center: No Charge Outpatient Hospital: No Charge	Ambulatory Surgery Center: Not Covered Outpatient Hospital: Not Covered	-----None-----
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	Facility Fee: \$50/visit Physician Fee: No Charge	Facility Fee: \$50/visit Physician Fee: No Charge	Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit.
	Emergency medical transportation	No Charge	No Charge	This payment is for emergency or authorized transport.
	Urgent care	\$15/visit	Within Plan Service Area: Not Covered Outside Plan Service Area: \$15/visit	-----None-----

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PENDING REGULATORY APPROVAL

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15/visit Other Outpatient Services: No Charge Partial Hospitalization: No Charge Neuropsychological and Psychological Testing: No Charge	Office Visit: Not Covered Other Outpatient Services: Not Covered Partial Hospitalization: Not Covered Neuropsychological and Psychological Testing: Not Covered	Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	Physician Inpatient Services: No Charge Hospital Services: No Charge Residential Care: No Charge	Physician Inpatient Services: Not Covered Hospital Services: Not Covered Residential Care: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	No Charge	Not Covered	-----None-----
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	

*For more information about limitations and exceptions, see the [plan](#) or policy document at www.blueshieldca.com/calpers.

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PENDING REGULATORY APPROVAL

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$15/visit	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result or non-payment of benefits.
	Rehabilitation services	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	-----None-----
	Habilitation services	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	
	Skilled nursing care	Freestanding Skilled Nursing Facility (SNF): No Charge Hospital-based Skilled Nursing Facility (SNF): No Charge	Freestanding Skilled Nursing Facility (SNF): Not Covered Hospital-based Skilled Nursing Facility (SNF): Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member calendar year
	Durable medical equipment	No Charge	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result non-payment of benefits.
	Hospice services	No Charge	Not Covered	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

*For more information about limitations and exceptions, see the [plan](#) or policy document at www.blueshieldca.com/calpers.

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 | • Weight loss programs |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care | |

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

- | | | |
|---------------------|---------------------|----------------------------|
| • Acupuncture | • Chiropractic care | • Infertility treatment |
| • Bariatric surgery | • Hearing aids | • Routine eye care (Adult) |

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 [ccio.cms.gov](https://www.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](https://www.healthcare.gov) or call 1-800-318-2596.

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: 1-800-334-5847 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](https://www.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 shika' 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): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում եմ 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 ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

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

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

Hmong (Hnoob): 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): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, 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

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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 [Plan](#) pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

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	\$0
Copayments	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$80

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

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	\$0
Copayments	\$550
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$610

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

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	\$0
Copayments	\$80
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$80