BLUE SHIELD OF CALIFORNIA

Summary of Benefits Comparison

California Schools Employee Benefits Association (CSEBA) - Effective July 1, 2020 PPO Plans

ASO PPO Gold (20 500/1500 90/70), Silver (30 1000/3000 80/60), Bronze Savings Plan (2700/5400)

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Benefit plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Provider Network:

Full PPO Network

This benefit plan uses a specific network of health care providers, called the Full PPO provider network. Medical groups, independent practice associations (IPAs), and physicians in this network are called participating providers. You must select a primary care physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this plan. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Benefit plan. (v) indicates that CYD applies.

		When using a participating provider[3]			When using a non-participating provider[3]		
		20 GOLD	30 SILVER	BRONZE	20 GOLD	30 SILVER	BRONZE
Calendar year medical deductible	Individual coverage	$500	$1000	$2800	$500	$2000	$2800
	Family coverage						
	Individual:	$500	$1000	$2800	$500	$2000	$2800
	Family:	$1500	$3000	$5400	$1500	$6000	$5400

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

		When using a participating provider[3]			When using a non-participating provider[3]		
		20 GOLD	30 SILVER	BRONZE	20 GOLD	30 SILVER	BRONZE
Calendar year out of pocket max	Individual coverage	$1,500	$4,000	$5,800	$6,000	$8,000	$11,600
	Family coverage: Individual	$3,000	$4,000	$5,800	$6,000	$8,000	$11,600
	Family	$6,000	$8,000	$11,600	$6,000	$16,000	$23,200

No Annural or Lifetime Dollar Limit
Under this plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services

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Benefits[5]	Your Payment		
When using a participating prodvider[3]	**20 GOLD**	**30 SILVER**	**BRONZE**
Preventive Health Services[6]	$0	$0	$0
Physician services			
Primary care office visit	$20/visit	$30/visit	$10/visit
Specialist care office visit	$20/visit	$30/visit	$10/visit
Physician home visit	10% √	20% √	20% √
Physician or surgeon services in an outpatient facility	10% √	20% √	20% √
Physician or surgeon services in an inpatient facility	10% √	20% √	20% √
Other professional services			
Other practitioner office visit	$20/visit	$30/visit	$10/visit
Includes nurse practitioners, physician assistants, and therapists.			
Acupunture Services- up to 12 visits/member/CYD	10% √	20% √	20% √
Chiropractic Services- upto 24 visits/member/CYD	10% √	20% √	20% √
Teladoc consultation	$5/consult	$5/consult	$5/consult
Family planning			
Counseling, consulting, and education	$0	$0	$0
Injectable contraceptive	$0	$0	$0
Diaphragm fitting	$0	$0	$0
Intrauterine device (IUD)	$0	$0	$0
Insertion and/or removal of IUD	$0	$0	$0
Implantable contraceptive	$0	$0	$0
Tubal ligation	$0	$0	$0
Vasectomy	10% √	20% √	20% √
Diagnosis & Treatment of the Cause of infertility	Not Covered	Not Covered	Not Covered
Podiatric services	$20/visit	$30/visit	$10/visit √
Pregnancy and maternity care[6]			
Physician office visits: prenatal and postnatal	10% √	20% √	20% √
Physician services for pregnancy termination	10% √	20% √	20% √
Emergency services and urgent care			
Emergency room services *	$150/visit + 10%	$150/visit + 20%	20% √
Emergency room physician services	10% √	20% √	20% √
Urgent care center services	$20/visit	$30/visit	$10/visit √
Ambulance services	10% √	20% √	20% √
Outpatient facility services			
Ambulatory surgery center	10% √	20% √	20% √
Outpatient department of a hospital: surgery	10% √	20% √	20% √
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10% √	20% √	20% √
Inpatient facility services			
Hospital services and stay	10% √	20% √	20% √

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Benefits[5]	Your Payment		
When using a participating	15 PLTNM	20 GOLD	20 Silver
Transplant services*			
Special transplant facility inpatient services	10% √	20% √	20% √
Physician inpatient services	10% √	20% √	20% √
Bariatric surgery services, designated CA counties			
Travel expenses will vary by plan. See individual benefit summary for more information			
Inpatient facility services	10% √	20% √	20% √
Outpatient facility services	10% √	20% √	20% √
Physician services	10% √	20% √	20% √
Diagnostic x-ray, imaging, pathology, and laboratory services*			
Laboratory services			
Includes diagnostic Papanicolaou (Pap) test.			
Laboratory center	10% √	20% √	20% √
Outpatient department of a hospital	10% √	20% √	20% √
X-ray and imaging services			
Includes diagnostic mammography.			
Outpatient radiology center	10% √	20% √	20% √
Outpatient department of a hospital	10% √	20% √	20% √
Other outpatient diagnostic testing*			
Office location	10% √	20% √	20% √
Outpatient department of a hospital	10% √	20% √	20% √
Radiological and nuclear imaging services			
Outpatient radiology center	10% √	20% √	20% √
Outpatient department of a hospital	10% √	20% √	20% √
Rehabilitation and habiliattive services			
Office location	10% √	$30/visit	20% √
Outpatient department of a hospital	10% √	20% √	20% √
Speech Therapy			
Office location	10% √	20% √	20% √
Outpatient department of a hospital	10% √	20% √	20% √
Durable medical equipment (DME)			
DME	10% √	20% √	20% √
Breast pump	$0	$0	$0
Orthotic equipment and devices	10% √	20% √	20% √
Prosthetic equipment and devices	10% √	20% √	20% √
Home health care services*	10% √	20% √	20% √
Home infusion & home injectable therapy services			
Home infusion agency services (incl. medical supplies)	10% √	20% √	20% √
Home visits by an infusion nurse	10% √	20% √	20% √
Hemophilia home infusion services	10% √	20% √	20% √
Includes blood factor products.			

Benefits[5]	Your Payment		
When using a participating	15 PLTNM	20 GOLD	20 Silver
Skilled nursing facility (SNF) services*			
Freestanding SNF	10% √	20% √	20% √
Hospital-based SNF	10% √	20% √	20% √
Hospice program services			
Includes pre-hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.	$0	20% √	20% √
Other services and supplies			
Diabetes care services			
Devices, equipment, and supplies	10% √	20% √	20% √
Self-management training	$20/visit	$30/visit	$10/visit √
Dialysis services	10% √	20% √	20% √
PKU product formulas and special food products	10% √	20% √	20% √
Allergy serum billed separately from an office visit	10% √	20% √	20% √
Hearing Services			
Hearing aids & equipment - 1 pair/member/36 months	N/A	N/A	20% √
Audiological Evaluation	N/A	N/A	$10/visit √
Wigs	N/A	N/A	20% √

Mental Health and Substance Use Disorder Benefits	Your payment		
When using a MHSA participating provider[3]	15 PLTNM	20 GOLD	20 Silver
Outpatient services			
Office visit, including physician office visit	$20/visit	$30/visit	$10/visit √
Intensive outpatient care	10% √	20% √	20% √
Behavioral Health Treatment in an office setting	$20/visit	$30/visit	$10/visit √
Behavioral Health Treatment in home or other non-institutional setting	10% √	20% √	20% √
Office based opiod treatment	10% √	20% √	20% √
Partial hospitalization program	10% √	20% √	20% √
Psychological testing	10% √	20% √	20% √
Inpatient services			
Physician inpatient services	10% √	20% √	20% √
Hospital services	10% √	20% √	20% √
Residential care	10% √	20% √	20% √

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Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see Blueshield.ca.com/pharmacy)

Please review the Benefit Booklet for more about Benefits that require prior authorization.

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the benefits, limitations, and exclusions that apply to coverage under this benefit plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before Blue Shield pays for Covered Services under the benefit plan.

If this benefit plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (√) in the Benefits chart above.

3 Using Participating

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Your payment f or services f rom "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a benefit
Essential health benefits count towards the OOPM.
Family coverage has an individual OOPM within the family OOPM. This means that the OOPM will be met for an individual with family coverage who meets the individual OOPM prior to the family meeting the family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health

If you only receive Preventive Health Services during a physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the physician office visit, you may have a Copayment or Coinsurance for the visit.

Notes

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
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BLUE SHIELD OF CALIFORNIA

CSEBA
ASO PPO Rx

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Effective: July 1, 2020

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Calendar Year Pharmacy Deductible (CYPD)

A CYPD is the amount a member pays each Calendar Year before the Claims Administer pays for covered Drugs under the outpatient prescription Drug Benefit. The Claims Administator pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Chart below.

Pharmacy Network: Rx Ultra

Drug Formulary: Plus Formulary

	PPO Rx Gold 10/30/50		PPO Rx Silver 15/30/50		PPO Bronze Savings Plan 2700/5400	
	Participating Providers[1]	**Non-Participating Providers[2]**	**Participating Providers[1]**	**Non-Participating Providers[2]**	**Participating Providers[1]**	**Non-Participating Providers[2]**
Calendar Year Pharmacy Deductible (Deductible amounts accrue separately for Participating and Non-	$0	$0	$0	$0	$2,800 per individual / $5,400 per family	

	Your Payment		Your Payment		Your Payment	
	PPO Rx Gold 10/30/50		PPO Rx Silver 15/30/50		PPO Bronze Savings Plan 2700/5400	
PRESCRIPTION DRUG	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions *(Per prescription, up to a 30-day Supply)*						
Contraceptive drugs and devices[15]	$0/prescription	Applicable Tier 1, Tier 2, or Tier 3 Copayment	$0/prescription	Applicable Tier 1, Tier 2, or Tier 3 Copayment	$0	Applicable Tier 1, Tier 2, or Tier 3 Copayment √
Value Based Tier Drugs	N/A	N/A	N/A	N/A	$0 √	Not Covered
Tier 1 drugs	$10/prescription	25% + $10/prescription	$15/prescription	25% + $15/prescription	$10/prescription √	25% + $10/prescription √
Tier 2 drugs	$30/prescription	25% + $30/prescription	$30/prescription	25% + $30/prescription	$25/prescription √	25% + $25/prescription √
Tier 3 drugs	$50/prescription	25% + $50/prescription	$50/prescription	25% + $50/prescription	$50/prescription √	25% + $50/prescription √
Tier 4 drugs *(excluding Specialty drugs)*	30% up to $150/prescription	30% up to $150/prescription + 25% of purchase price	30% up to $200/prescription	30% up to $200/prescription + 25% of purchase price	30% up to $200/prescription √	30% up to $200/prescription +25% of purchase price √
Mail Service Prescriptions *(Per prescription, up to a 90-day Supply)*						
Contraceptive drugs and devices[15]	$0	Not Covered	$0	Not Covered	$0	Not Covered
Value Based Tier Drugs	N/A	N/A	N/A	N/A	$0 √	Not Covered
Tier 1 drugs	$20/prescription	Not Covered	$30/prescription	Not Covered	$20/prescription √	Not Covered
Tier 2 drugs	$60/prescription	Not Covered	$60/prescription	Not Covered	$50/prescription √	Not Covered
Tier 3 drugs	$100/prescription	Not Covered	$100/prescription	Not Covered	$100/prescription √	Not Covered
Tier 4 drugs (excluding Specialty drugs)	30% up to $300/prescription	Not Covered	30% up to $400/prescription	Not Covered	30% up to $400/prescription √	Not Covered
Network Specialty Pharmacy Drugs *(Per prescription, up to a 30-day*						
Tier 4 - Specialty drugs *(includes orally administered anti-cancer medications)*	30% up to + $150/prescription	Not Covered	30% up to $200/prescription	Not Covered	30% up to $200/prescription √	Not Covered
Oral Anticance Drugs *(Per prescription, up to a 30-day Supply)*	30% up to +$150/prescription	Not Covered	30% up to $200/prescription	Not Covered	30% up to $200/prescription √	Not Covered

NOTES:

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (√) in the Benefits chart above.
Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by the Claims Administrator before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (√) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.
Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/wellness/drugs/formulary#heading2

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Heath Care Provider select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to the Claims Administrator for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Benefit designs may be modified to ensure compliance with Federal requirements.

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