BLUE SHIELD OF CALIFORNIA

Summary of Benefits Comparison

California Schools Employee Benefits Association (CSEBA) - Effective July 1, 2020 HMO Benefit Plan

CSEBA Trio ACO HMO Plans

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:

Trio ACO HMO Network

This benefit plan uses a specific network of health care providers, called the Trio ACO HMO 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.
(√) indicates that CYD applies.

When using a participating provider[3]

		15 PLTNM	20 GOLD	20 Silver	40 Bronze
Calendar year medical deductible	Individual coverage	$0	$0	$500	$1500
	Family coverage				
	Individual:	$0	$0	$500	$1,500
	Family:	$0	$0	$1,000	$3,000

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]

		15 PLTNM	20 GOLD	20 Silver	40 Bronze
Calendar year out of pocket max	Individual coverage	$1,500	$2,500	$3,000	$4,000
	Family coverage: Individual	$1,500	$2,500	$3,000	$4,000
	Family	$3,000	$5,000	$6,000	$8,000

continued

Benefits[5]	Your Payment			
When using a participating prodvider[3]	15 PLTNM	20 GOLD	20 Silver	40 Bronze
Preventive Health Services[6]	$0	$0	$0	$0
California Prenatal Screening Program	$0	$0	$0	$0
Physician services				
Primary care office visit	$15/visit	$20/visit	$20/visit	$40/visit
Trio+ specialist care office visit (self-referral)	$25/visit	$30/visit	$30/visit	$50/visit
Other specialist care office visit (referred by PCP)	$15/visit	$20/visit	$20/visit	$40/visit
Physician home visit	$15/visit	$20/visit	$20/visit	$40/visit
Physician or surgeon services in an outpatient facility	$0	$0	$0	$0
Physician or surgeon services in an inpatient facility	$0	$0	$0	$0
Other professional services				
Other practitioner office visit	$15/visit	$20/visit	$20/visit	$40/visit
Includes nurse practitioners, physician assistants, and therapists.				
Teladoc consultation	$0	$0	$0	$0
Family planning				
Counseling, consulting, and education	$0	$0	$0	$0
Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	$0	$0	$0
Tubal ligation	$0	$0	$0	$0
Vasectomy	$50/surgery	$50/surgery	$50/surgery	$50/surgery
Podiatric services	$15/visit	$20/visit	$20/visit	$40/visit
Pregnancy and maternity care[6]				
Physician office visits: prenatal and postnatal	$15/visit	$20/visit	$0	$40/visit
Physician services for pregnancy termination	$0	$0	$0	$0
Emergency services and urgent care				
Emergency room services *	$100/visit	$100/visit	10%	30%
Emergency room physician services	$0	$0	$0	$0
Urgent care center services	$15/visit	$20/visit	$20/visit	$40/visit
Ambulance services	$100/Transport	$100/Transport	$150/Transport	$150/Transport
Outpatient facility services				
Ambulatory surgery center	$50/surgery	$250/surgery	10% √	30% √
Outpatient department of a hospital: surgery	$50/surgery	$250/surgery	10% √	30% √
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	$0	$0	$0
Inpatient facility services				
Hospital services and stay	$100/admission	$500/admission	10% √	30% √
Transplant services*				
Special transplant facility inpatient services	$100/admission	$500/admission	10% √	30% √
Physician inpatient services	$0	$0	$0	$0

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Benefits[5] — **Your Payment** — *continued*

When using a participating prodvider[3]	15 PLTNM	20 GOLD	20 Silver	40 Bronze
Diagnostic x-ray, imaging, pathology, and laboratory services*				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
Laboratory center	$0	$0	$10/visit	$10/visit
Outpatient department of a hospital	$0	$0	$10/visit	$10/visit
X-ray and imaging services				
Includes diagnostic mammography.				
Outpatient radiology center	$0	$0	$10/visit	$10/visit
Outpatient department of a hospital	$0	$0	$10/visit	$10/visit
Other outpatient diagnostic testing*				
Office location	$0	$0	$10/visit	$10/visit
Outpatient department of a hospital	$0	$0	$10/visit	$10/visit
Radiological and nuclear imaging services				
Outpatient radiology center	$0	$100/visit	$50/visit	$50/visit
Outpatient department of a hospital	$0	$100/visit	$50/visit	$50/visit
Rehabilitation and habiliattive services (Incl. Physical, Occupational, & Respiratory Therapy)				
Office location	$15/visit	$20/visit	$20/visit	$40/visit
Outpatient department of a hospital	$15/visit	$20/visit	$20/visit	$40/visit
Durable medical equipment (DME)				
DME	$0	20%	20%	20%
Breast pump	$0	$0	$0	$0
Orthotic equipment and devices	$0	$0	$0	$0
Prosthetic equipment and devices	$0	$0	$0	$0
Home health care services* (up to 100 visits/member/calendar year)	$15/visit	$20/visit	$20/visit	$40/visit
Home Infusion & home injectable therapy services				
Home visits by an infusion nurse	$15/visit	$20/visit	$20/visit	$40/visit
Home infusion agency services *(Incl. home infusion drugs & medical supplies)*	$0	$0	$0	$0
Hemophilia home infusion services *(Includes blood factor products)*	$0	$0	$0	$0
Skilled nursing facility (SNF) services*				
Freestanding SNF	$0	$0	10% √	30% √
Hospital-based SNF	$0	$0	10% √	30% √
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	$0	$0	$0
Other services and supplies				
Diabetes care services				
Devices, equipment, and supplies	$0	$0	$0	$0

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continued

Benefits[5] When using a participating prodvider[3]	Your Payment 15 PLTNM	20 GOLD	20 Silver	40 Bronze
Self-management training	$15/visit	$20/visit	$20/visit	$40/visit
Dialysis services	$0	$0	$0	$0
PKU product formulas and special food products	$0	$0	$0	$0
Allergy serum billed separately from an office visit	$0	$0	$0	$0

Mental Health and Substance Use Disorder Benefits When using a MHSA participating provider[3]	Your payment 15 PLTNM	20 GOLD	20 Silver	40 Bronze
Outpatient services				
Office visit, including physician office visit	$15/visit	$20/visit	$20/visit	$40/visit
Other outpatient services, including intensive outpatient care, behavioral health treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	$0	$0	$0
Partial hospitalization program	$0	$0	$0	$0
Psychological testing	$0	$0	$0	$0
Inpatient services				
Physician inpatient services	$0	$0	$0	$0
Hospital services	$100/admission	$500/admission	10% √	30% √
Residential care	$100/admission	$500/admission	10% √	30% √

Notes

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.

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 Providers: 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-of-Pocket Maximum (OOPM): Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a benefit maximum.
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 Services:
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.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

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CSEBA
Trio HMO Basic Rx
Outpatient Prescription Drug Rider

SUMMARY OF BENEFITS:
The summary of benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network: Rx Ultra
Drug Formulary: Plus Formulary

Calendar Year Pharmacy Deductible
A Calendar Year Pharmacy Deductible is the amount a member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits Chart below.

Covered Services	Member Copayment	Member Copayment
	Trio HMO Platinum 15 & Gold 20 Members	**Trio HMO Silver 20 & Bronze 40 Members**
Calendar Year Pharmacy Deductible	None	None
PRESCRIPTION DRUG COVERAGE[1,2,3,4]	**When using a Participating Pharmacy**[5]	**When using a Participating Pharmacy**[5]
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive drugs and devices[6]	$0	$0
• Tier 1 drugs	$10/prescription	$10/prescription
• Tier 2 drugs	$20/prescription	$30/prescription
• Tier 3 drugs	Not Covered	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	20% up to $150/prescription	20% up to $150/prescription
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive drugs and devices[6]	$0/prescription	$0/prescription
• Tier 1 drugs	$20/prescription	$20/prescription
• Tier 2 drugs	$40/prescription	$60/prescription
• Tier 3 drugs	Not Covered	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	20% up to $300/prescription	20% up to $300/prescription
Network Specialty Pharmacy Drugs (up to a 30-day supply)		
• Tier 4 - Specialty drugs[8]	20% up to $150/prescription	20% up to $150/prescription
Oral Anticancer Drugs (up to a 30-day supply)	20% up to $150/prescription	20% up to $150/prescription

1 Amounts paid through copayments and any applicable pharmacy deductible accrues to the member's medical calendar year out-of-pocket maximum. Please refer to the *Evidence of Coverage* and Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Drugs obtained at a non-participating pharmacy are not covered, unless Medically Necessary for a covered emergency.

3 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the Tier 1 drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

5 Coinsurance is calculated based on the contracted rate. When the Participating Pharmacy’s contracted rate is less than the Member’s Copayment or Coinsurance, the Member only pays the contracted rate.

6 Contraceptive drugs and devices covered under the outpatient prescription drug benefits will not be subject to the calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment. The member may receive up to a 12-month supply of contraceptive Drugs.

7 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost.

8 Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup. Oral anticancer medications are not subject to the calendar year pharmacy deductible.

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continued

Note: This plan's 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 plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 83 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you would be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to www.blueshieldca.com/bsca/pharmacy/home.sp and log onto My Health plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of www.blueshieldca.com/bsca/pharmacy/home.sp and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescription.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 711.

Plan designs may be modified to ensure compliance with state and Federal requirements

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