CSEBA Medical Marketplace for 2019
HMO Platinum Plans

BENEFITS	Blue Shield of California: Platinum HMO ACCESS+ Network	Blue Shield of California: Platinum HMO Trio ACO Network	Kaiser Plan: Platinum HMO Kaiser
Annual Deductible (per calendar year)	None	None	None
Maximum Out of Pocket (per calendar year)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Office Visit Copay (PCP/Urgent Care)	$15/visit	$15/visit	$15/visit
Access Plus Specialist Visit	$25/visit	$25/visit	N/A
Teledoc	$5 copay	$5 copay	No copay
Preventive	No copay	No copay	No copay
Hospital Medical Services			
Inpatient Services	$100 per admit	$100 per admit	$100 per admit
Outpatient Services			
Outpatient Surgery & Supplies	$50 copay	$50 copay	$50 copay
X-Rays and Lab Tests (when performed in non-hospital based facility)	No copay	No copay	No copay
Advanced Imaging (MRI, CT, PET)	No copay	No copay	No copay
Chiropractic and Accupuncture (30 visits per year)	$10 Chiro; $10 Accupuncture	$10 Chiro; $10 Accupuncture	$10 Chiro; $10 Accupuncture
Durable Medical Equipment	No copay	No copay	No copay
Emergency			
Ambulance Services	$100/trip	$100/trip	$100/trip
Emergency Services Copay	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Mental Health and Substance Abuse			
Inpatient Hospital Physician	No copay	No copay	No copay
Outpatient Visits	$15/visit	$15/visit	$15/visit
Inpatient Hospital Services	$100 per admit	$100 per admit	$100 per admit
Prescription Drug Copay			Generic/Brand/Non-Formulary
Tier 1	$10 copay	$10 copay	$10 copay
Tier 2	$20 copay	$20 copay	$20 copay
Tier 3	$40 copay	Only covered with prior authorization	Only covered with prior authorization
Tier 4 (non-specialty and specialty)	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum
Mail Order	2 times retail	2 times retail	2 times retail

Note: All Trio plans wlll be Closed Formulary

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2019
HMO Gold Plans

BENEFITS	Blue Shield of California Gold HMO ACCESS+ Network	Blue Shield of California Gold HMO Trio ACO Network	Kaiser Plan Gold HMO Kaiser
Annual Deductible (per calendar year)	None	None	None
Maximum Out of Pocket (per calendar year)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Office Visit Copay (PCP/Urgent Care)	$20/visit	$20/visit	$20/visit
Access Plus Specialist Visit	$30/visit	$30/visit	N/A
Teledoc	$5 copay	$5 copay	No copay
Preventive	No copay	No copay	No copay
Hospital Medical Services			
Inpatient Services	$500 per admit	$500 per admit	$500/admit
Outpatient Services			
Outpatient Surgery & Supplies	$250 copay	$250 copay	$250 copay
X-Rays and Lab Tests (when performed in non-hospital based facility)	No copay	No copay	No copay
Advanced Imaging (MRI, CT, PET)	$100/visit	$100/visit	$100/test
Radiation Therapy, Chemotherapy & Hemeodialysis Treatment & Infusion Therapy	No copay	No copay	No copay
Chiropractic and Accupuncture (30 visits per year)	$10 Chiro; $10 Accupuncture	$10 Chiro; $10 Accupuncture	$10 Chiro - $10 Accupuncture
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Emergency			
Ambulance Services	$100/trip	$100/trip	$100/trip
Emergency Services Copay	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Mental Health and Substance Abuse			
Inpatient Hospital Physician	No copay	No copay	No copay
Outpatient Visits	$20/visit	$20/visit	$20/visit
Inpatient Hospital Services	$500 per admit	$500 per admit	$500 per admit
Prescription Drug Copay			Generic/Brand/Non-Formulary
Tier 1	$10 copay	$10 copay	$10 copay
Tier 2	$20 copay	$20 copay	$20 copay
Tier 3	$40 copay	Only covered with prior authorization	Only covered with prior authorization
Tier 4 (non-specialty and specialty)	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum
Mail Order	2 times retail	2 times retail	2 times retail

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2019
Silver Plans

	Blue Shield of California		Kaiser Plan
BENEFITS	**Silver HMO ACCESS+ Network**	**Silver HMO Trio ACO Network**	**Silver HMO Kaiser**
Annual Deductible (per calendar year)	$500 / $1,000	$500 / $1,000	$500/$1,000
Maximum Out of Pocket (per calendar year)	$3000/$6000	$3000/$6000	$3000/$6000
Office Visit Copay (PCP/Urgent Care)	$20/visit	$20/visit	$20 visit
Access Plus Specialist Visit	$30/visit	$30/visit	N/A
Teledoc	$5 copay	$5 copay	No copay
Preventive	No copay	No copay	No copay
Hospital Medical Services			
Inpatient Services	10% after deductible	10% after deductible	10% after deductible
Outpatient Services			
Outpatient Surgery & Supplies	10% after deductible	10% after deductible	10% after deductible
X-Rays and Lab Tests (when performed in non-hospital based facility)	$10 copay	$10 copay	$10 copay
Advanced Imaging (MRI, CT, PET)	$50/visit	$50/visit	10% up to $50/visit
Radiation Therapy, Chemotherapy & Hemeodialysis Treatment & Infusion Therapy	No copay	No copay	No Copay
Chiropractic and Accupuncture (30 visits per year)	$15 Chiro/$15 accupuncture	$15 Chiro/$15 accupuncture	$15 Chiro/$15 accupuncture
Durable Medical Equipment	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)
Emergency			
Ambulance Services	$150/trip	$150/trip	$150/trip
Emergency Services Copay	10% coinsurance (deductible doesn't apply; waived if admitted)	10% coinsurance (deductible doesn't apply; waived if admitted)	10% coinsurance after deductible (waived if admitted)
Mental Health and Substance Abuse			
Inpatient Hospital Physician	No copay	No copay	No copay
Outpatient Visits	$20/visit	$20/visit	$20/visit
Inpatient Hospital Services	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible
Prescription Drug Copay			Generic/Brand/Non-Formulary
Tier 1	$10 copay	$10 copay	$10 copay
Tier 2	$30 copay	$30 copay	$30 copay
Tier 3	$50 copay	Only covered with prior authorization	Only covered with prior authorization
Tier 4	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum
Mail Order	2 times retail	2 times retail	2 times retail

Note: All Trio plans wlll be Closed Formulary

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2019
Bronze Plans

BENEFITS	Blue Shield of California Bronze HMO ACCESS+ Network	Bronze HMO Trio ACO Network	Kaiser Plans Bronze HMO Kaiser	Bronze HMO II Kaiser H.S.A. Plan (All services subject to deductible except preventive)
Annual Deductible (per calendar year)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$2,700/$5,400
Maximum Out of Pocket (per calendar year)	$4,000/$8,000	$4,000/$8,000	$4,00/$8,000	$5,400/$10,800
Office Visit Copay (PCP/Urgent Care)	$40/visit	$40/visit	$40/visit	$10/visit
Access Plus Specialist Visit	$50/visit	$50/visit	N/A	N/A
Teledoc	$5 copay	$5 copay	No copay	No copay
Preventive	No copay	No copay	No copay	No copay
Hospital Medical Services				
Inpatient Services	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Outpatient Services				
Outpatient Surgery & Supplies	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
X-Rays and Lab Tests (when performed in non-hospital based facility)	$10 copay	$10 copay	$10 copay	20% coinsurance after deductible
Advanced Imaging (MRI, CT, PET)	$50/visit	$50/visit	30% up to $50/visit	20% coinsurance after deductible
Radiation Therapy, Chemotherapy & Hemeodialysis Treatment & Infusion Therapy	No copay	No copay	No copay	20% coinsurance after deductible
Chiropractic and Acupuncture (30 visits per year)	$15 Chiro/$15 accupuncture	$15 Chiro/$15 accupuncture	$15 Chiro/$15 accupuncture	Not covered
Durable Medical Equipment	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)	20% coinsurance after deductible
Emergency				
Ambulance Services	$150/trip	$150/trip	$150/trip	20% coinsurance after deductible
Emergency Services Copay	30% coinsurance (deductible doesn't apply; waived if admitted)	30% coinsurance (deductible doesn't apply; waived if admitted)	30% coinsrance after deductible (waived if admitted)	20% coinsurance after deductible (waived if admitted)
Mental Health and Substance Abuse				
Inpatient Hospital Physician	No copay	No copay	No copay	No copay
Outpatient Visits	$40/visit	$40/visit	$40/visit	$10/visit
Inpatient Hospital Services	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Prescription Drug Copay			Generic/Brand/Non-Formulary	Generic/Brand/Non-Formulary
Tier 1	$10 copay	$10 copay	$10 copay	$10 copay
Tier 2	$30 copay	$30 copay	$30 copay	$25 copay
Tier 3	$50 copay	Only covered with prior authorization	Only covered with prior authorization	Only covered with prior authorization
Tier 4	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum	20% coinsurance to $150 maximum	30% coinsurance to $150 maximum
Mail Order	2 times retail	2 times retail	2 times retail	2 times retail
Prescription - Out of Pocket Maximum				

*Outpatient copay applies as follows: Surgicenter = lower copay; Hospital = higher copay

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2019
PPO Plans
Blue Shield of California

BENEFITS	Gold PPO		Silver PPO		Bronze PPO/HSA Plan Subject to the Deductible (except Preventive Services)	
	Participating PPO	*Non-participating PPO*	*Participating PPO*	*Non-participating PPO*	*Participating PPO*	*Non -Participating PPO*
Annual Deductible (per calendar year):						
Individual / Family	$500/$1,500	$1,000/$3,000	$1,000/$3,000	$2,000/$6,000	$2,700/$5,400	
Maximum Out of Pocket (per calendar year):						
Individual / Family	$3,000/$6,000	$6,000/$12,000	$4,000/$8,000	$8,000/$16,000	$5,000/$10,000	$10,000/$20,000
Office Visit Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance	$10 copay	30% coinsurance
Urgent Care Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance	$10 copay	30% coinsurance
Teledoc (Not subject to deductible)	$5	Not covered	$5	Not covered	$5	Not covered
Preventive Care Copay	No copay	30% coinsurance	No copay	40% coinsurance	No copay	30% coinsurance
Hospital Medical Services						
Inpatient Services	10% coinsurance	30% coinsurance limited to $600 per day	20% coinsurance	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient Services						
Outpatient Surgery Facility	10% coinsurance	30% coinsurance (limited to $350 per day)	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Lab and X-Ray	10% coinsurance	30% coinsurance (limited to $350 per day)	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Advanced Imaging (MRI, CT, PET)	10% coinsurance	30% coinsurance (limited to $350 per day)	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Chiropractic Services (limited to 24 visits per calendar year)	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Acupuncture - Services for disease, illness or injury (limited to 12	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Home Infusion; Hemodialysis	10% coinsurance	Not covered (unless prior authorized and paid at in-network benefit)	20% coinsurance	Not covered (unless prior authorized and paid at in-network benefit)	20% coinsurance	Not covered (unless prior authorized and paid at in-network benefit)
Durable Medical Equipment	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Emergency Services Copay	$150 copay (waived if admitted) + 10% (not subject to deductible)		$150 copay (waived if admitted) + 20% (not subject to deductible)		20% coinsurance	20% coinsurance
Ambulance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health and Substance Abuse						
Inpatient (Physician visit)	10% coinsurance	30% coinsurance	20%	40% coinsurance	20% coinsurance	30% coinsurance
Inpatient (Facility-based care)	10% coinsurance	30% coinsurance limited to $600 per day	20%	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient	$20 (ded. waived)	30% coinsurance	$30 (ded. waived)	40% coinsurance	$10 copay	30% coinsurance
Prescription Drug Copay					Subject to Deductible	
Tier 1	$10 copay	$10 copay + 25% of billed amount	$15 copay	$15 copay + 25% of billed amount	$10 copay	$10 copay + 25% of billed amount
Tier 2	$30 copay	$30 copay + 25% of billed amount	$30 copay	$30 copay + 25% of billed amount	$25 copay	$25 copay + 25% of billed amount
Tier 3	$50 Copay	$50 copay + 25% of billed amount	$50 Copay	$50 copay + 25% of billed amount	$50 Copay	$50 copay + 25% of billed amount
Specialty	30% coinsurance to $150 maximum	Not covered	30% coinsurance to $200 maximum	Not covered	30% coinsurance to $200 maximum	Not covered
Mail Order	2 times retail copay	Not covered	2 times retail copay	Not covered	2 times retail copay	Not covered

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