CSRM CSEBA
California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
HMO Platinum Plans

BENEFITS	Blue Shield of California Platinum HMO ACCESS+ Network	Blue Shield of California Platinum HMO Trio ACO Network	Kaiser Permanente 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 (Direct Referral in Medical Group)	$25/visit	$25/visit	N/A
Teledoc / Telehealth	$5/consult	No copay	No copay
Preventive	No copay	No copay	No copay
Hospital Medical Services			
Inpatient Services	$100 per admission	$100 per admission	$100 per admission
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 Acupuncture (30 combined visits per year)	$10 Chiro; $10 Acupuncture	$10 Chiro; $10 Acupuncture	$10 Chiro; $10 Acupuncture
Durable Medical Equipment	No copay	No copay	No copay
Emergency			
Ambulance ServicesAmbulance Services	$100/transport	$100/transport	$100/transport
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 admission	$100 per admission	$100 per admission
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 prescription maximum	20% coinsurance to $150 prescription maximum	20% coinsurance to $150 prescription maximum
Mail Order	2 times retail	2 times retail	2 times retail

Note: All Trio plans will be Closed Formulary

The information in these charts are summaries only. For a complete understanding of benefits, please refer to the EOC (Evidence of Coverage). The EOC contains a detailed explanation of benefits, exclusions and limitations. We reserve the right to modify the rates and benefits if we receive further clarification of Federal Health Reform requirements.

CSRM CSEBA
California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
HMO Gold Plans

BENEFITS	Blue Shield of California Gold HMO ACCESS+ Network	Blue Shield of California Gold HMO Trio ACO Network	Kaiser Permanente 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 (Direct Referral in Medical Group)	$30/visit	$30/visit	N/A
Teledoc / Telehealth	$5/consult	No copay	No copay
Preventive	No copay	No copay	No copay
Hospital Medical Services			
Inpatient Services	$500 per admission	$500 per admission	$500 per admission
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/procedure
Radiation Therapy, Chemotherapy & Hemeodialysis Treatment & Infusion Therapy	No copay	No copay	No copay
Chiropractic and Acupuncture (30 combined visits per year)	$10 Chiro; $10 Acupuncture	$10 Chiro; $10 Acupuncture	$10 Chiro - $10 Acupuncture
Durable Medical Equipment	10% coinsurance	10% coinsurance	10% coinsurance
Emergency			
Ambulance ServicesAmbulance Services	$100/transport	$100/transport	$100/transport
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 admission	$500 per admission	$500 per admission
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 prescription maximum	20% coinsurance to $150 prescription maximum	20% coinsurance to $150 prescription maximum
Mail Order	2 times retail	2 times retail	2 times retail

Note: All Trio plans will be Closed Formulary

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CSRM CSEBA
California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
Silver Plans

BENEFITS	Blue Shield of California Silver HMO ACCESS+ Network	Blue Shield of California Silver HMO Trio ACO Network	Kaiser Permanente Silver HMO Kaiser
Annual Deductible (per calendar year)	$500 / $1,000	$500 / $1,000	$500/$1,000
Maximum Out of Pocket (per calendar year)	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Office Visit Copay (PCP/Urgent Care)	$20/visit	$20/visit	$20 visit
Access Plus Specialist (Direct Referral in Medical Group)	$30/visit	$30/visit	N/A
Teledoc / Telehealth	$5/consult	No 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 Acupuncture (30 combined visits per year)	$15 Chiro/$15 acupuncture	$15 Chiro/$15 acupuncture	$15 Chiro/$15 acupuncture
Durable Medical Equipment	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)	20% coinsurance (deductible doesn't apply)
Emergency			
Ambulance ServicesAmbulance Services	$150/transport	$150/transport	$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 prescription maximum	20% coinsurance to $150 prescription maximum	20% coinsurance to $150 prescription maximum
Mail Order	2 times retail	2 times retail	2 times retail

Note: All Trio plans will be Closed Formulary

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CSRM CSEBA
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RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
Bronze Plans

	Blue Shield of California		Kaiser Permanente	
BENEFITS	**Bronze HMO ACCESS+ Network**	**Bronze HMO Trio ACO Network**	**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	$2,800/$5,600
Maximum Out of Pocket (per calendar year)	$4,000/$8,000	$4,000/$8,000	$4,00/$8,000	$5,600/$11,200
Office Visit Copay (PCP/Urgent Care)	$40/visit	$40/visit	$40/visit	$10/visit after plan deductible
Access Plus Specialist (Direct Referral in Medical Group)	$50/visit	$50/visit	N/A	N/A
Teledoc / Telehealth	$5 copay	No copay	No copay	No copay after deductible
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 combined visits per year)	$15 Chiro/$15 acupuncture	$15 Chiro/$15 acupuncture	$15 Chiro/$15 acupuncture	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 ServicesAmbulance Services	$150/transport	$150/transport	$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 after deductible
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 after deductible
Tier 2	$30 copay	$30 copay	$30 copay	$25 copay after deductible
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 prescription max	20% coinsurance to $150 prescription max	20% coinsurance to $150 prescription max	30% coinsurance to $150 maximum after ded.
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

Note: All Trio plans will be Closed Formulary

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
Full PPO Plans
Blue Shield of California

BENEFITS	Gold PPO		Silver PPO	
	Participating PPO	*Non-participating PPO*	*Participating PPO*	*Non-participating PPO*
Annual Deductible (per cal. year): Individual / Family	$500/$1,500	$1,000/$3,000	$1,000/$3,000	$2,000/$6,000
Max Out of Pocket (per cal. year): Individual / Family	$3,000/$6,000	$6,000/$12,000	$4,000/$8,000	$8,000/$16,000
Office Visit Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance
Urgent Care Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance
Teledoc (Not subject to deductible)	$5/consult (ded. waived)	Not covered	$5/consult (ded. waived)	Not covered
Preventive Care Copay	$0 (ded. waived)	30% coinsurance	$0 (ded. waived)	40% coinsurance
Hospital Medical Services				
Inpatient Services	10% coinsurance	30% coinsurance limited to $600 per day	20% coinsurance	40% 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)
Lab and X-Ray	10% coinsurance	30% coinsurance (limited to $350 per day)	20% coinsurance	40% 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)
Chiropractic Services (limited to 24 visits per calendar year)	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance
Acupuncture - Services for disease, illness or injury (limited to 12 per year)	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance
Durable Medical Equipment	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance
Emergency Services Copay	$150 copay (waived if admitted) + 10% (not subject to deductible)		$150 copay (waived if admitted) + 20% (not subject to deductible)	
Ambulance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Mental Health and Substance Abuse				
Inpatient (Physician visit)	10% coinsurance	30% coinsurance	20%	40% coinsurance
Inpatient (Facility-based care)	10% coinsurance	30% coinsurance limited to $600 per day	20%	40% coinsurance limited to $600 per day
Outpatient (Physician visit)	$20 (ded. waived)	30% coinsurance	$30 (ded. waived)	40% coinsurance
Plus Formulary Prescription Drug				
Tier 1	$10 copay	$10 copay + 25% of billed amount	$15 copay	$15 copay + 25% of billed amount
Tier 2	$30 copay	$30 copay + 25% of billed amount	$30 copay	$30 copay + 25% of billed amount
Tier 3	$50 Copay	$50 copay + 25% of billed amount	$50 Copay	$50 copay + 25% of billed amount
Tier 4 (non-specialty and specialty)	30% coinsurance to $150 prescription max	30% coinsurance up to $150 max +25% of billed amount	30% coinsurance to $200 prescription max	30% coinsurance up to $200 max +25% of billed amount
Mail Order	2 times retail copay	Not covered	2 times retail copay	Not covered

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
HSA (Full PPO) Plans
Blue Shield of California

BENEFITS	CSEBA Premier HDHP Silver Alternate HSA (Full PPO)		CSEBA Premier HDHP Bronze HSA (Full PPO)	
	Participating PPO	*Non-participating PPO*	Subject to the Deductible (except Preventive Services) *Participating PPO*	*Non -Participating PPO*
Annual Deductible (per cal. year):				
Individual / Family	$1,500/$3,000		$2,800/$5,400	
Max Out of Pocket (per cal. year):				
Individual / Family	$4,000/$8,000	$8,000/$16,000	$5,800/$11,600	$11,600/$23,200
Office Visit Copay	$10/visit after plan deductible	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Urgent Care Copay	$10/visit after plan deductible	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Teledoc (Not subject to deductible)	$5/consult (ded. waived)	Not covered	$5/consult after plan deductible	Not covered
Preventive Care Copay	$0 (ded. waived)	40% coinsurance	No copay	30% coinsurance
Hospital Medical Services				
Inpatient Services	20% coinsurance	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient Services				
Outpatient Surgery Facility	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Lab and X-Ray	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Advanced Imaging (MRI, CT, PET)	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)	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Acupuncture - Services for disease, illness or injury (limited to 12 per year)	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Emergency Services Copay	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health and Substance Abuse				
Inpatient (Physician visit)	20%	40% coinsurance	20% coinsurance	30% coinsurance
Inpatient (Facility-based care)	20%	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient (Physician visit)	$10 (ded. waived)	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Plus Formulary Prescription Drug Copay			Subject to Deductible	
Tier 1	$10 copay	$10 copay + 25% of billed amount	$10 copay/after ded.	$10 copay + 25% of billed amount
Tier 2	$25 copay	$25 copay + 25% of billed amount	$25 copay/after ded.	$25 copay + 25% of billed amount
Tier 3	$50 Copay	$50 copay + 25% of billed amount	$50 copay/after ded.	$50 copay + 25% of billed amount
Tier 4 (non-specialty and specialty)	30% coinsurance to $200 prescription max	30% coinsurance up to $200 max +25% of billed amount	30% coinsurance to $200 maximum	30% coinsurance up to $200 max +25% of billed amount
Mail Order	2 times retail copay	Not covered	2 times retail copay	Not covered

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The CSEBA Premier HDHP was introduced in 2020. Districts with CSEBA Medical Plans for more than 10 years will receive an added benefit as part of their High Deducltible HSA plans for Blue Shield. This plan includes built in: Critical Illness Program, Accident Plan and Hospitality Indemnity Plan.

California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
Tandem PPO Plans
Blue Shield of California

BENEFITS	Gold Tandem PPO		Silver Tandem PPO	
	Participating PPO	*Non-participating PPO*	*Participating PPO*	*Non-participating PPO*
Annual Deductible (per cal. year): Individual / Family	$500/$1,500	$1,000/$3,000	$1,000/$3,000	$2,000/$6,000
Max Out of Pocket (per cal. year): Individual / Family	$3,000/$6,000	$6,000/$12,000	$4,000/$8,000	$8,000/$16,000
Office Visit Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance
Urgent Care Copay	$20 copay (ded. waived)	30% coinsurance	$30 copay (ded. waived)	40% coinsurance
Teledoc (Not subject to deductible)	$5/consult (ded. waived)	Not covered	$5/consult (ded. waived)	Not covered
Preventive Care Copay	$0 (ded. waived)	30% coinsurance	$0 (ded. waived)	40% coinsurance
Hospital Medical Services				
Inpatient Services	10% coinsurance	30% coinsurance limited to $600 per day	20% coinsurance	40% 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)
Lab and X-Ray	10% coinsurance	30% coinsurance (limited to $350 per day)	20% coinsurance	40% 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)
Chiropractic Services (limited to 24 visits per calendar year)	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance
Acupuncture - Services for disease, illness or injury (limited to 12	10% coinsurance	30% coinsurance	20% coinsurance	40% 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)
Durable Medical Equipment	10% coinsurance	30% coinsurance	20% coinsurance	40% coinsurance
Emergency Services Copay	$150 copay (waived if admitted) + 10% (not subject to deductible)		$150 copay (waived if admitted) + 20% (not subject to deductible)	
Ambulance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Mental Health and Substance Abuse				
Inpatient (Physician visit)	10% coinsurance	30% coinsurance	20%	40% coinsurance
Inpatient (Facility-based care)	10% coinsurance	30% coinsurance limited to $600 per day	20%	40% coinsurance limited to $600 per day
Outpatient (Physician visit)	$20 (ded. waived)	30% coinsurance	$30 (ded. waived)	40% coinsurance
Value Formulary Prescription Drug				
Tier 1	$10 copay	$10 copay + 25% of billed amount	$15 copay	$15 copay + 25% of billed amount
Tier 2	$30 copay	$30 copay + 25% of billed amount	$30 copay	$30 copay + 25% of billed amount
Tier 3	$50 Copay	$50 copay + 25% of billed amount	$50 Copay	$50 copay + 25% of billed amount
Tier 4 (non-specialty and specialty)	30% coinsurance to $150 maximum	30% coinsurance up to $150 max +25% of billed amount	30% coinsurance to $200 maximum	30% coinsurance up to $200 max +25% of billed amount
Mail Order	2 times retail copay	Not covered	2 times retail copay	Not covered

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California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSEBA Medical Marketplace for 2022
Tandem HSA (PPO) Plans
Blue Shield of California

BENEFITS	CSEBA Premier HDHP Silver Alternate Tandem HSA / PPO		CSEBA Premier HDHP Bronze Tandem HSA / PPO	
	Participating PPO	*Non-participating PPO*	Subject to the Deductible (except Preventive Services) *Participating PPO*	*Non -Participating PPO*
Annual Deductible (per cal. year):				
Individual / Family	$1,500/$3,000		$2,800/$5,400	
Max Out of Pocket (per cal. year):				
Individual / Family	$4,000/$8,000	$8,000/$16,000	$5,800/$11,600	$11,600/$23,200
Office Visit Copay	$10/visit after plan deductible	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Urgent Care Copay	$10/visit after plan deductible	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Teledoc (Not subject to deductible)	$5/consult (ded. waived)	Not covered	$5/consult after plan deductible	Not covered
Preventive Care Copay	$0 (ded. waived)	40% coinsurance	No copay	30% coinsurance
Hospital Medical Services				
Inpatient Services	20% coinsurance	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient Services				
Outpatient Surgery Facility	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Lab and X-Ray	20% coinsurance	40% coinsurance (limited to $350 per day)	20% coinsurance	30% coinsurance (limited to $350 per day)
Advanced Imaging (MRI, CT, PET)	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)	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Acupuncture - Services for disease, illness or injury (limited to 12 per year)	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance	20% coinsurance	30% coinsurance
Emergency Services Copay	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health and Substance Abuse				
Inpatient (Physician visit)	20%	40% coinsurance	20% coinsurance	30% coinsurance
Inpatient (Facility-based care)	20%	40% coinsurance limited to $600 per day	20% coinsurance	30% coinsurance limited to $600 per day
Outpatient (Physician visit)	$10 (ded. waived)	40% coinsurance	$10/visit after plan deductible	30% coinsurance
Plus Formulary Prescription Drug Copay			Subject to Deductible	
Tier 1	$10 copay	$10 copay + 25% of billed amount	$10 copay/after ded.	$10 copay + 25% of billed amount
Tier 2	$25 copay	$25 copay + 25% of billed amount	$25 copay/after ded.	$25 copay + 25% of billed amount
Tier 3	$50 Copay	$50 copay + 25% of billed amount	$50 copay/after ded.	$50 copay + 25% of billed amount
Tier 4 (non-specialty and specialty)	30% coinsurance to $200 prescription max	30% coinsurance up to $200 max +25% of billed amount	30% coinsurance to $200 maximum	30% coinsurance up to $200 max +25% of billed amount
Mail Order	2 times retail copay	Not covered	2 times retail copay	Not covered

The information in these charts are summaries only. For a complete understanding of benefits, please refer to the EOC (Evidence of Coverage). The EOC contains a detailed explanation of benefits, exclusions and limitations. We reserve the right to modify the rates and benefits if we receive further clarification of Federal Health Reform requirements.

The CSEBA Premier HDHP was introduced in 2020. Districts with CSEBA Medical Plans for more than 10 years will receive an added benefit as part of their High Deducltible HSA plans for Blue Shield. This plan includes built in: Critical Illness Program, Accident Plan and Hospitality Indemnity Plan.