blue of california

**Santa Ana Unified School District**
**Effective July 1, 2020**
**PPO Plan**

# Summary of Benefits

## Custom PPO Classified

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

### Medical Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. 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 Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

| | | When using a Participating Provider[3] | When using a Non-Participating Provider[4] |
|---|---|---|---|
| **Calendar Year medical Deductible** | *Individual coverage* | $300 | $600 |
| | *Family coverage* | $300: individual | $600: individual |
| | | $600: Family | $1,200: Family |

### Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

| | When using a Participating Provider[3] | When using any combination of Participating[3] or Non-Participating[4] Providers |
|---|---|---|
| *Individual coverage* | $1,300 | $2,600 |
| *Family coverage* | $1,300: individual | $2,600: individual |
| | $2,600: Family | $5,200: Family |

### No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Preventive Health Services[7]** | | | | |
| Preventive Health Services | $0 | | 30% | ✔ |
| California Prenatal Screening Program | $0 | | $0 | |
| **Physician services** | | | | |
| Primary care office visit | $20/visit | | 30% | ✔ |
| Specialist care office visit | $20/visit | | 30% | ✔ |
| Physician home visit | $20/visit | | 30% | ✔ |
| Physician or surgeon services in an outpatient facility | 10% | ✔ | 30% | ✔ |
| Physician or surgeon services in an inpatient facility | 10% | ✔ | 30% | ✔ |
| **Other professional services** | | | | |
| Other practitioner office visit | $20/visit | | 30% | ✔ |
| *Includes nurse practitioners, physician assistants, and therapists.* | | | | |
| Acupuncture services | 20% | | 30% | |
| Chiropractic services | 20% | ✔ | 30% | ✔ |
| *Up to 50 visits per Member, per Calendar Year.* | | | | |
| Teladoc consultation | $5/consult | | Not covered | |
| Family planning | | | | |
| • Counseling, consulting, and education | $0 | | Not covered | |
| • Injectable contraceptive | $0 | | Not covered | |
| • Diaphragm fitting | $0 | | Not covered | |
| • Intrauterine device (IUD) | $0 | | 30% | ✔ |
| • Insertion and/or removal of Intrauterine device (IUD) | $0 | | 30% | ✔ |
| • Implantable contraceptive | $0 | | Not covered | |
| • Tubal ligation | $0 | | Not covered | |
| • Vasectomy | 10% | ✔ | Not covered | |
| Podiatric services | $20/visit | | 30% | ✔ |
| **Pregnancy and maternity care[7]** | | | | |
| Physician office visits: prenatal and postnatal | 10% | ✔ | 30% | ✔ |
| Physician services for pregnancy termination | 10% | ✔ | 30% | ✔ |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Emergency services** | | | | |
| Emergency room services<br>*If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.* | $100/visit | | $100/visit | |
| Emergency room Physician services | 10% | | 10% | |
| **Urgent care center services** | $20/visit | | 30% | ✔ |
| **Ambulance services**<br>*This payment is for emergency or authorized transport.* | 10% | ✔ | 10% | ✔ |
| **Outpatient facility services** | | | | |
| Ambulatory Surgery Center | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Outpatient Department of a Hospital: surgery | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| **Inpatient facility services** | | | | |
| Hospital services and stay | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Transplant services<br>*This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.* | | | | |
| • Special transplant facility inpatient services | 10% | ✔ | Not covered | |
| • Physician inpatient services | 10% | ✔ | Not covered | |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Bariatric surgery services, designated California counties** | | | | |
| *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.* | | | | |
| Inpatient facility services | 10% | ✔ | Not covered | |
| Outpatient facility services | 10% | ✔ | Not covered | |
| Physician services | 10% | ✔ | Not covered | |
| **Diagnostic x-ray, imaging, pathology, and laboratory services** | | | | |
| *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.* | | | | |
| Laboratory services | | | | |
| *Includes diagnostic Papanicolaou (Pap) test.* | | | | |
| • Laboratory center | 20% | ✔ | 30% | ✔ |
| • Outpatient Department of a Hospital | 20% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| X-ray and imaging services | | | | |
| *Includes diagnostic mammography.* | | | | |
| • Outpatient radiology center | 20% | ✔ | 30% | ✔ |
| • Outpatient Department of a Hospital | 20% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Other outpatient diagnostic testing | | | | |
| *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.* | | | | |
| • Office location | 20% | ✔ | 30% | ✔ |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| • Outpatient Department of a Hospital | 20% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Radiological and nuclear imaging services | | | | |
| • Outpatient radiology center | 20% | ✔ | 30% | ✔ |
| • Outpatient Department of a Hospital | 20% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| **Rehabilitative and Habilitative Services** | | | | |
| *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.* | | | | |
| Office location | 20% | ✔ | 30% | ✔ |
| Outpatient Department of a Hospital | 20% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| **Durable medical equipment (DME)** | | | | |
| DME | 20% | ✔ | 30% | ✔ |
| Breast pump | $0 | | 30% | ✔ |
| Orthotic equipment and devices | 10% | ✔ | 30% | ✔ |
| Prosthetic equipment and devices | 10% | ✔ | 30% | ✔ |
| **Home health care services** | 20% | ✔ | Not covered | |
| *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.* | | | | |
| **Home infusion and home injectable therapy services** | | | | |
| Home infusion agency services | 20% | ✔ | Not covered | |
| *Includes home infusion drugs and medical supplies.* | | | | |
| Home visits by an infusion nurse | 20% | ✔ | Not covered | |
| Hemophilia home infusion services | 20% | ✔ | Not covered | |
| *Includes blood factor products.* | | | | |

| Benefits[6] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Skilled Nursing Facility (SNF) services**<br>*Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.* | | | | |
| Freestanding SNF | 10% | ✔ | 10% | ✔ |
| Hospital-based SNF | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| **Hospice program services**<br>*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 | | Not covered | |
| **Other services and supplies** | | | | |
| Diabetes care services | | | | |
| • Devices, equipment, and supplies | 20% | ✔ | 30% | ✔ |
| • Self-management training | $20/visit | | 30% | ✔ |
| Dialysis services | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| PKU product formulas and Special Food Products | 10% | ✔ | 10% | ✔ |
| Allergy serum billed separately from an office visit | 10% | ✔ | 30% | ✔ |
| Hearing services | | | | |
| • Hearing aids and equipment<br>*Up to $2000 combined maximum per Member, per 24 months.* | $0 | | $0 | |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | |
|---|---|---|---|---|
| *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).* | When using a MHSA Participating Provider[3] | CYD[2] applies | When using a MHSA Non-Participating Provider[4] | CYD[2] applies |
| **Outpatient services** | | | | |
| Office visit, including Physician office visit | $10/visit | | 30% | ✔ |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | |
|---|---|---|---|---|
| *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).* | **When using a MHSA Participating Provider[3]** | **CYD[2] applies** | **When using a MHSA Non-Participating Provider[4]** | **CYD[2] applies** |
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, 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 | ✔ | 30% | ✔ |
| Partial Hospitalization Program | $0 | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Psychological Testing | $0 | ✔ | 30% | ✔ |
| **Inpatient services** | | | | |
| Physician inpatient services | 10% | ✔ | 30% | ✔ |
| Hospital services | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |
| Residential Care | 10% | ✔ | 30% of up to $1,500/day plus 100% of additional charges | ✔ |

## 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

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

## Notes

**1 Evidence of Coverage (EOC):**

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this 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.

*Capitalized terms are defined in the EOC.* Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

**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 Plan.

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

*Covered Services not subject to the Calendar Year medical Deductible*. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

*This Plan has a separate Participating Provider Deductible and Non-Participating Provider Deductible*.

*Family coverage has an individual Deductible within the Family Deductible*. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

**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.

*"Allowable Amount" is defined in the EOC.* In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

**4 Using Non-Participating Providers:**

*Non-Participating Providers do not have a contract to provide health care services to Members.* When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

*"Allowable Amount" is defined in the EOC.* In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

**5 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.*

## Notes

*Any Deductibles count towards the OOPM.* Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

*This Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM.* This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider 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.

**6 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.

**7 Preventive Health Services:**

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a Participating Provider. 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.

Plans may be modified to ensure compliance with State and Federal requirements.
MS041620

# Pharmacy Benefit Overview | Santa Ana Union School District

## PPO 2 Plan

Express Scripts manages the prescription-drug benefits for Santa Ana Union School District employees. We are here to help you save money and get the best service on prescriptions for you and your family. Your Express Scripts benefit includes:

- 24/7 access to the Patient Care Contact Center
- You can fill maintenance medication up to three times at retail pharmacy before a penalty is incurred

### Copayments for Your Prescription-Drug Program

| **Prescriptions from a Participating Retail Pharmacy** (up to a 30 day supply) | **Prescriptions from Express Scripts Pharmacy (Home Delivery)** (up to a 90 day supply) |
|---|---|
| Generic medication: $15.00 Copay | Generic medication: $30.00 Copay |
| Preferred brand-name medication: $30.00 Copay | Preferred brand-name medication: $60.00 Copay |
| Non-preferred brand-name medication: $50.00 Copay | Non-preferred brand-name medication: $100.00 Copay |
| Specialty medication: 30% Co-insurance with $150 max | |
| Deductible: $150 Brand Drugs only | |
| Out of pocket Max (Individual/Family): $5,300/$10,600 | |

### How to Get Prescriptions from a Participating Retail Pharmacy

You will need to show this Express Scripts ID card to your pharmacist each time you get a prescription filled. You can locate pharmacies near you that are in the Express Scripts network by visiting Express-scripts.com or calling Express Scripts at 877-474-1136.

### How to Get Started with the Express Scripts Pharmacy & Home Delivery

To get started with home delivery from the Express Scripts Pharmacy, either login at Express-scripts.com or call Express Scripts at the number listed on the back of your ID card. Please allow 14 business days to receive your first prescription.

### Savings with Generics

FDA-approved generics are as safe and effective as their brand-name counterparts. If you're taking a brand-name drug, talk to your doctor and ask whether a less expensive generic drug could treat your condition. If your doctor agrees, ask your doctor to write a new prescription for the generic that you can fill through your prescription benefit.

*If you purchase a brand-name medication when a generic medication is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic.

### How to Get Started with the Accredo Specialty Pharmacy

Accredo provides specialized patient care for those with complex conditions like cancer, Hepatitis C or Multiple Sclerosis, including ongoing support from pharmacists and nurses with specialized training and expertise. Start by reaching out to Express Scripts at 800-803-2523 or visit Accredo.com.

### Resources

- **24-hour Customer Service:** If you have questions about your prescription-drug benefit, please visit express-scripts.com or call Express Scripts at 877-474-1136. The phone number can be found on the back of your ID card.
- **Express Scripts Website:** www.express-scripts.com