



Summary of Benefits

California Schools Employee Benefits Association (CSEBA)
Effective July 1, 2026
PPO Plan

ASO Tandem PPO Silver

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.¹ Please read both documents carefully for details.

Provider Network:

Tandem PPO Network

This Plan uses a specific network of Health Care Providers, called the Tandem 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 the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator 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	<i>Individual coverage</i>	\$1,000	\$2,000
	<i>Family coverage</i>	\$1,000: individual	\$2,000: individual
		\$3,000: Family	\$6,000: Family

Calendar Year Out-of-Pocket Maximum⁵

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.

No Annual 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.

	When using a Participating Provider ³	When using a Non-Participating Provider ⁴
<i>Individual coverage</i>	\$4,000	\$8,000
<i>Family coverage</i>	\$4,000: individual	\$8,000: individual
	\$8,000: Family	\$16,000: Family

Blue Shield of California is an independent member of the Blue Shield Association

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		Not covered	
Physician services				
Primary care office visit	\$30/visit		40%	✓
Specialist care office visit	\$30/visit		40%	✓
Physician home visit	20%	✓	40%	✓
Physician or surgeon services in an Outpatient Facility	20%	✓	40%	✓
Physician or surgeon services in an inpatient facility	20%	✓	40%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$30/visit		40%	✓
Acupuncture services <i>Up to 12 visits per Member, per Calendar Year.</i>	20%	✓	40%	✓
Chiropractic services <i>Up to 24 visits per Member, per Calendar Year.</i>	20%	✓	40%	✓
Teladoc Health consultation	\$0		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		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	\$0		Not covered	
• Implantable contraceptive	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	\$0		40%	✓
Podiatric services	\$30/visit		40%	✓
Medical nutrition therapy, not related to diabetes	20%	✓	40%	✓
Infertility Services				
Physician or surgeon services in an Outpatient Facility	20%	✓	40%	✓
Artificial Inseminations limited to 6 per lifetime	20%	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Oocyte (egg) retrieval limited to 3 per lifetime				
<ul style="list-style-type: none"> Ambulatory Surgery Center 	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
In vitro fertilization (IVF)	20%	✓	40%	✓
Embryo transfer				
<ul style="list-style-type: none"> Ambulatory Surgery Center 	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	20%	✓	40%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✓	40%	✓
Abortion and abortion-related services	\$0		\$0	
Emergency Services				
Emergency room services	\$150/visit plus 20%	✓	\$150/visit plus 20%	✓
<i>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.</i>				
Emergency room Physician services	20%	✓	20%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Urgent care center services	\$30/visit		40%	✓
Ambulance services <i>This payment is for emergency or authorized transport.</i>	20%	✓	20%	✓
Outpatient Facility services				
Ambulatory Surgery Center	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: surgery	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Inpatient facility services				
Hospital services and stay	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Transplant services <i>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.</i> <i>Travel expenses for an authorized, specified transplant: recipient & companion transportation limited to \$10,000/transplant. Unrelated donor search, limited to \$30,000/transplant.</i>				
• Special transplant facility inpatient services	20%	✓	Not covered	
• Physician inpatient services	20%	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<p>Bariatric surgery services, designated California counties</p> <p><i>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.</i></p> <p><i>Travel expenses for an authorized, specialized surgery: recipient & companion transportation limited to \$3,000/surgery.</i></p>				
Inpatient facility services	20%	✓	Not covered	
Outpatient Facility services	20%	✓	Not covered	
Physician services	20%	✓	Not covered	
<p>Diagnostic x-ray, imaging, pathology, and laboratory services</p> <p><i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i></p> <p>Laboratory and pathology services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p> <ul style="list-style-type: none"> Laboratory center 20% ✓ 40% ✓ Outpatient Department of a Hospital 20% ✓ Subject to a Benefit maximum of \$350/day ✓ <p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p> <ul style="list-style-type: none"> Outpatient radiology center 20% ✓ 40% ✓ Outpatient Department of a Hospital 20% ✓ Subject to a Benefit maximum of \$350/day ✓ 				

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Other outpatient non-invasive diagnostic testing				
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
• Office location	20%	✓	40%	✓
• Outpatient Department of a Hospital	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Advanced imaging services				
<i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>				
• Outpatient radiology center	20%	✓	40%	✓
• Outpatient Department of a Hospital	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>				
Office location	\$30/visit	✓	40%	✓
Outpatient Department of a Hospital	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Speech Therapy services				
Office location	20%	✓	40%	✓
Outpatient Department of a Hospital	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Durable medical equipment (DME)				
DME	20%	✓	40%	✓
Breast pump	\$0		Not covered	
Orthotic equipment and devices	20%	✓	40%	✓
Prosthetic equipment and devices	20%	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<p>Home health care services</p> <p><i>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.</i></p>	20%	✓	Not covered	
<p>Home infusion and home injectable therapy services</p> <p>Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i></p> <p>Hemophilia home infusion services <i>Includes blood factor products.</i></p>	20%	✓	Not covered	
<p>Skilled Nursing Facility (SNF) services</p> <p><i>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.</i></p> <p>Freestanding SNF</p> <p>Hospital-based SNF</p>	20%	✓	20% 40% Subject to a Benefit maximum of \$600/day	✓ ✓
<p>Hospice program services</p> <p>Pre-Hospice consultation</p> <p>Routine home care</p> <p>24-hour continuous home care</p> <p>Short-term inpatient care for pain and symptom management</p> <p>Inpatient respite care</p>	20%	✓	Not covered	
<p>Other services and supplies</p> <p>Diabetes care services</p> <ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training • Medical nutrition therapy 	20% \$30/visit \$30/visit	✓	40% 40% 40%	✓ ✓ ✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Dialysis services	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
PKU product formulas and special food products	20%	✓	20%	✓
Allergy serum billed separately from an office visit	20%	✓	40%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Outpatient services				
Office visit, including Physician office visit	\$30/visit		40%	✓
Teladoc Health mental health	\$0		Not covered	
Intensive outpatient care	20%	✓	40%	✓
Behavioral Health Treatment in an office setting	\$30/visit		40%	✓
Behavioral Health Treatment in home or other non-institutional setting	20%	✓	40%	✓
Office-based opioid treatment	20%	✓	40%	✓
Partial Hospitalization Program	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	20%	✓	40%	✓
Inpatient services				
Physician inpatient services	20%	✓	40%	✓
Hospital services	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Residential Care	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓

Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

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

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

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

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator 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 the Claims Administrator 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 Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.
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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

Notes

- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Deductible or 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):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

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

This Plan has a separate Participating Provider OOPM 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 payment in addition to an allergy serum payment 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. 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 Federal requirements.

Pb022026

ASO PPO Rx Spectrum \$15/30/50/30% with Value Formulary
Summary of Benefits

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

Pharmacy Network:	Rx Spectrum
Drug Formulary:	Value Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for covered Drugs under the outpatient prescription Drug Benefit. The Claims Administrator pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² or Non-Participating³ Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy ²		CYPD ¹ applies	When using a Non-Participating Pharmacy ³	CYPD ¹ applies
	Level A	Level B			
Retail pharmacy prescription Drugs					
<i>Per prescription, up to a 30-day supply.</i>					
Contraceptive Drugs and devices	\$0	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Value-Based Tier Drugs	\$0	\$0		Not covered	
Tier 1 Drugs	\$0	\$15/prescription		25% plus \$15/prescription	
Tier 2 Drugs	\$20/prescription	\$30/prescription		25% plus \$30/prescription	
Tier 3 Drugs	\$50/prescription	\$50/prescription		25% plus \$50/prescription	

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Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy ²		CYPD ¹ applies	When using a Non-Participating Pharmacy ³	CYPD ¹ applies
Tier 4 Drugs	30% up to \$200/prescription	30% up to \$200/prescription		30% up to \$200/prescription plus 25% of purchase price	
Retail pharmacy prescription Drugs					
<i>Per prescription, for a 90-day supply.</i>					
Contraceptive Drugs and devices	\$0	\$0		Not covered	
Value-Based Tier Drugs	\$0	\$0		Not covered	
Tier 1 Drugs	\$0	\$45/prescription		Not covered	
Tier 2 Drugs	\$60/prescription	\$90/prescription		Not covered	
Tier 3 Drugs	\$150/prescription	\$150/prescription		Not covered	
Tier 4 Drugs	30% up to \$600/prescription	30% up to \$600/prescription		Not covered	
Mail service pharmacy prescription Drugs					
<i>Per prescription, for a 31-90-day supply.</i>					
Contraceptive Drugs and devices		\$0		Not covered	
Value-Based Tier Drugs		\$0		Not covered	
Tier 1 Drugs		\$0		Not covered	
Tier 2 Drugs		\$40/prescription		Not covered	
Tier 3 Drugs		\$100/prescription		Not covered	
Tier 4 Drugs		30% up to \$400/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.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

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. Blue Shield has two participation levels for retail pharmacies; Level A and Level B. You can go to any Level A or Level B pharmacy to obtain covered Drugs. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://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 or Biosimilar Drug is available. If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to the Claims Administrator for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. 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.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a 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.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Retail pharmacy. You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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