Blue Shield of California PPO

SAME PLAN FOR ACTIVES AND RETIREES

Please check the LBUSD Benefit website for a copy of the Evidence of Coverage (EOC): **www.lbusdwellness.com**.

This booklet is intended to provide highlights of your benefits only; it is not an Evidence of Coverage (EOC) plan document. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including a complete list of exclusions and limitations, please refer to each carrier's EOC.

	In-Network	Out-of-Network
Plan Year Deductible	$300/person; $600/family	$500/person; $1,000/family
Coinsurance	20% of allowable amounts	40% of allowable amounts
Plan Year Out-of-Pocket Maximum (includes deductible)	$1,300/person; $2,600/family	$5,500/person; $11,000/family
Lifetime Maximum	Unlimited	Unlimited
Inpatient Hospital	20% of allowable amounts	40% up to $600 per day, and all charges over $600 per day
Surgeon	20% of allowable amounts	40% of allowable amounts
Outpatient Surgery	20% of allowable amounts	40% up to $350 per day, and all charges over $350 per day
Ambulatory Surgery Center and Outpatient Services	20% of allowable amounts	40% up to $350 per day, and all charges over $350 per day
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Physician Visits	20% of allowable amounts	40% of allowable amounts
Prenatal and Postnatal	20% of allowable amounts	40% of allowable amounts
X-ray and Laboratory	20% of allowable amounts[1]	40% of allowable amounts
Chiropractic	20% of allowable amounts	40% of allowable amounts
Ambulance	20% of allowable amounts	20% of allowable amounts
Dental	No coverage	No coverage
Vision	No coverage	No coverage
Routine Physicals	No charge	40% of allowable amounts
Mental Health		
Inpatient	20% of allowable amounts	40% up to $600 per day, and all charges over $600 per day
Outpatient	20% of allowable amounts	40% of allowable amounts

Prescription Drugs	In-Network-Only[2]	
Out-of-Pocket Maximum Individual/Family	$5,550/$11,100	
	Retail (30 day supply)[3]	**Mail Order** (90 day supply)
Generic	$5 copay	$0 copay
Brand	$20 copay	$20 copay
Non-formulary	$50 copay	$50 copay

[1] Women's preventive care and some routine tests and screenings for women are 100% covered in-network with no deductible required.

[2] Prescription drug coverage provided through Express Scripts. Some contraceptive prescriptions for women are 100% covered in-network with no copay or deductible required. Age limits may apply. Contact the plan for details.

[3] Diabetic medications are available in 90 day supplies at select retail pharmacies.