	BLUE SHIELD HMO PLATINUM POS PLAN ($10-$30 COPAY)		BLUE SHIELD HMO GOLD ACCESS+ PLAN ($40 COPAY)	BLUE SHIELD HMO GOLD TRIO PLAN ($20 COPAY)	BLUE SHIELD PPO NON-NEEDLES PLAN		KAISER HMO PLATINUM PLAN ($10 COPAY)	KAISER HMO GOLD PLAN ($40 COPAY)
	LEVEL I - HMO	**LEVEL II - PPO**	**ACCESS+HMO**	**TRIO HMO**	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**	**KAISER**	**KAISER**
Plan Network	Blue Shield Access+ HMO Network	Blue Shield PPO Network	Blue Shield Access+ HMO Network	Blue Shield Trio HMO Network	Shield PPO Network (includes Blue Card Program access)	Out-of-Network	Kaiser physicians and facilities only	Kaiser physicians and facilities only
Calendar year (CY)Deductible combined PPO/OON	None	None	None	None	$250 per individual $500 per family	$250 per individual $500 per family	None	None
Hospital or Ambulatory Surgical Center deductible	None	Not covered	None	None	None	None	None	None
Lifetime benefits maximum	None	None	None	None	None	None	None	None
Out-of-Pocket annual maximum	$1,500 per individual $3,000 per family	$8,00 per individual $16,000 per family	$3,500 per individual $7,000 per family	$3,500 per individual $7,000 per family	$1,750 per individual $3,000 per family	$2,250 per individual $4,500per family	$1,500 per individual $3,000 per family	$3,500 per individual $7,000 per family
Preexisting condition	Fully covered	Fully covered	Fully covered	Fully covered	Fully covered	Fully covered	Fully covered	Fully covered
Office/ Outpatient Care								
Office Visits – Primary Care Physician (PCP)	$10 copay	$30 copay	$40 copay	$20 copay	$10 copay (deductible does not apply)	You pay 30% after CY deductible	$10 copay	$40 copay
Office Visits – Specialist (self-referral within assigned PCP's medical group)	N/A	N/A	$50 copay	$20 copay	N/A	N/A	N/A	N/A
Office Visits -Specialist	$10 copay	$30 copay	$40 copay (referred by PCP)	$20 copay (referred by PCP)	$10 copay (deductible does not apply)	You pay 30% after CY deductible	$10 copay	$50 copay
Tele-Medicine	Covered through Teladoc 24/7 – No charge	Covered through Teladoc 24/7 – No charge	Covered through Teladoc 24/7 – No charge	Covered through Teladoc 24/7 - No charge	Covered through Teladoc 24/7 – No charge	Not covered	No charge	No charge
Preventive Services	No charge	$30 copay	No charge	No charge	No charge (CY deductible waived)	You pay 30% after CY deductible	No charge	No charge
Hearing screenings	No charge	$30 copay	No charge	No charge	No charge (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge
Immunizations	No charge	$30 copay	No charge	No charge	No charge (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge
Tubal ligation	No charge	Not covered	No charge	No charge	No charge (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge
Vasectomy	$10 copay/surgery	Not covered	$10 copay/surgery	$20 copay/surgery	You pay 20% after CY deductible	You pay 30% after CY deductible	$10 copay	$250 copay
Well baby/Well child care	No charge	$30 copay	No charge	No charge	No charge (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge
Well woman exam (annual)	No charge	$30 copay	No charge	No charge	No charge (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge

Emergency Medical Care								
Ambulance	No charge (for emergency or authorized transport)	No charge (for emergency or authorized transport)	No charge (for emergency or authorized transport)	No charge(for emergency or authorized transport)	You pay 20% after CY Deductible (for emergency or authorized transport)	You pay 20% after CY deductible (for emergency or authorized transport)	No charge when medically necessary	$150 copay when medically necessary
Emergency room (if admitted to the Hospital, see Hospitalization Services for cost share)	$50 copay/visit (does not apply if admitted)	$50 copay/visit (does not apply if admitted)	$50 copay/visit (does not apply if admitted)	$50 copay/visit (does not apply if admitted)	$50 copay/visit plus 20% after CY deductible; copay does not apply if admitted Physician: 20% after CY deductible	$50 copay/visit plus 20% after CY deductible; copay does not apply if admitted Physician: 20% after CY deductible	$50 copay (does not apply if admitted)	$150 copay (does not apply if admitted)
Urgent care	$10 copay	$10 copay	$40 copay	$20 copay	$10 copay (deductible does not apply)	30% after CY deductible	$10 copay	$40 copay
Diagnostic Services								
Laboratory and Pathology Tests	No charge	No charge	Outpatient department of Hospital – No charge Other – You pay 40%	Outpatient department of Hospital – No charge Other – You pay 40%	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	$10 copay.
Diagnostic Tests and X-Ray	No charge	Covered only when performed in physician's office Not covered for CT, MRI, MUGA, PET, and SPECT	Outpatient department of Hospital – No charge Other – You pay 40%	Outpatient department of Hospital – No charge Other – You pay 40%	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	$10 copay MRI, most CT and PET: $100 copay
Diabetes Care								
Covered Diabetic drugs and testing supplies	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"	See "Prescription Drugs"
Diabetes Self-Management Training & Education	No charge	$30 copay	Office Visit: $40 copay	Office Visit: $20 copay	$10 copay (deductible does not apply)	You pay 30% after CY deductible	No charge	No charge
Devices, Equipment, and Non-Testing Supplies	No charge	Not covered	You pay 40%	You pay 40%	You pay 20% after CY deductible	You pay 30% after CY deductible	See Durable Medical Equipment	See Durable Medical Equipment
Maternity Care								
Prenatal and Postnatal office visits	No charge	You pay 20% coinsurance	No charge	No charge	$10 copay after CY deductible	You pay 30% after CY deductible	No charge	No charge
Delivery (Professional Services)	No charge	Not covered	No charge	No charge	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	No charge
Newborn Care	Newborn covered 30 days; must enroll through the Teamsters 1932 Health Trust	Covered under HMO, Level I Benefit	No charge. Newborn covered 30 days; must enroll through the Teamsters 1932 Health Trust within 60 days of birth	No charge. Newborn covered 30 days; must enroll through the Teamsters 1932 Health Trust within 60 days of birth	Newborn covered 30 days; must enroll through the Teamsters 1932 Trust within 60 days of birth	Newborn covered 30 days; must enroll through the Teamsters 1932 Trust within 60 days of birth	Newborn covered 30 days; must enroll through the County within 60 days of birth	Newborn covered 30 days; must enroll through the County within 60 days

	within 60 days of birth							of birth
Hospital Services								
Hospital care (Hospital and Physician charges)	No charge	Not covered	Hospital: $100/admission plus 20% Physician: No charge	Hospital: $100/admission plus 20% Physician: No charge	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	$500copay per day
Surgical Services								
Hospital – In-Patient Surgical Services	No charge (Facility and Physician)	Not covered	Facility: $100 admission plus 20% Physician: No charge	Facility: $100 admission plus 20% Physician: No charge	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible	No charge (Facility and Physician)	Facility: $500 copay per day Physician: No charge
Outpatient / Ambulatory Surgery Center	No charge (Facility and Physician)	Not covered	Facility: You pay 40% Physician: No charge	Facility: You pay 40% Physician: No charge	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible	Facility: $10 copay per procedure Physician: No charge	Facility: $250 copay per procedure Physician: No charge
Alternatives to Hospital Care								
Home health services	No charge up to 100 visits per calendar year	Not covered	No charge up to 100 visits per calendar year	No charge up to 100 visits per calendar year	You pay 20% after CY deductible up to 100 visits per calendar year	Not covered	No charge up to 100 visits per accumulation period	No charge up to 100 visits per accumulation period
Hospice	No charge; includes routine home care, 24-hour continuous home care, short-term IP care for pain/ symptom management	Not covered	No charge; includes routine home care, 24- hour continuous home care, short-term IP care for pain/symptom management	No charge; includes routine home care, 24-hour continuous home care, short-term IP care for pain/symptom management	No charge (deductible does not apply) 24-hr continuous home care/Short-term inpatient care for pain and symptom mgmt.: You pay 20% after CY deductible	Not covered	No charge	No charge
Skilled nursing facilities (SNF)	No charge	Not covered	No charge up to 100 days per Benefit Period	No charge up to 100 days per Benefit Period	You pay 20% after CY deductible up 100 days per Benefit period - combined PPO/Non-PPO maximum	You pay 20% after CY deductible up 100 days per Benefit period - combined PPO/Non-PPO maximum Hospital based SNF: You pay 30% after CY deductible	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
Mental Health Care and Substance Abuse Treatment	**MHSA Participating Provider**	**MHSA Non-Participating Provider**	**MHSA Participating Provider**	**MHSA Participating Provider**	**MHSA Participating Provider**	**MHSA Non-Participating Provider**		
Outpatient services	$10 copay	$10 copay	$40 copay All other services are no charge	$20 copay All other services are no charge	Outpatient: $10 copay (deductible does not apply) All other services: You pay 20% after CY deductible	You pay 30% after CY deductible	$10 copay per individual $5 copay per group	$40 copay individual; $20 copay group Substance abuse: $5 copay group
Inpatient services	No charge	Not covered	Physician: No charge Hospital services and residential care: $100/ admission plus	Physician: No charge Hospital services and residential care: $100/ admission plus 20%	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	$500 copay per day

			20%					
Prescription Drugs								
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	Retail Pharmacy (30-day supply): Tier 1- $5 copay Tier 2 - $10 copay Tier 3 - $25 copay Tier 4 - $10 copay (excluding specialty drugs) Specialty Pharmacy: Tier 4 - $10 copay (Specialty Drugs 30-day supply) Mail order (90-day supply): Tier 1- $10 copay Tier 2 - $20 copay Tier 3 - $50 copay Tier 4 - $20 copay (excluding specialty drugs)	Not covered	Retail Pharmacy (30-day supply): Tier 1- $5 copay Tier 2 - $10 copay Tier 3 - $25 copay Tier 4 – 20% up to $200/Rx (excluding specialty drugs) Specialty Pharmacy: Tier 4 – 20% up to $200/Rx (Specialty Drugs 30- day supply) Mail order (90-day supply): Tier 1- $10 copay Tier 2 - $20 copay Tier 3 - $50 copay Tier 4 – 20% up to $400/Rx (excluding specialty drugs)	Retail Pharmacy (30-day supply): Tier 1- $5 copay Tier 2 - $10 copay Tier 3 - $25 copay Tier 4 – 20% up to $200/Rx (excluding specialty drugs) Specialty Pharmacy: Tier 4 – 20% up to $200/Rx (Specialty Drugs 30- day supply) Mail order (90-day supply): Tier 1- $10 copay Tier 2 - $20 copay Tier 3 - $50 copay Tier 4 – 20% up to $400/Rx (excluding specialty drugs)	**PARTICIPATING PHARMACY** Retail Pharmacy (30-day supply): Tier 1- $15 copay Tier 2 - $30 copay Tier 3 - $30 copay Tier 4 - $15 copay (excluding specialty drugs) Specialty Pharmacy: Tier 4 - $15 copay (Specialty Drugs 30- day supply) Mail order (90-day supply): Tier 1- $30 copay Tier 2 - $60 copay Tier 3 - $60 copay Tier 4 - $30 copay (excluding specialty drugs)	**NON-PARTICIPATING PHARMACY** Retail Pharmacy (30-day supply): (Member pays 25% of billed amount plus copay) Tier 1- $15 copay Tier 2 - $30 copay Tier 3 - $30 copay Tier 4 - $15 copay (excluding specialty drugs) Specialty Pharmacy: Not covered Mail order: Not covered	Pharmacy (up to a 100-day supply): Generic – $10 copay Brand – $15 copay Most specialty items - $15 copay (up to a 30-day supply) Mail order (up to a 100-day supply): Generic – $10 copay Brand – $15 copay	Pharmacy (up to a 30-day supply): Generic – $15 copay Brand – $35 copay Most specialty items: 30%, not to exceed $200 (up to a 30-day supply) Mail order (up to 100-day supply): Generic – $30 copay Brand – $70 copay
	Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum.				Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum	Pharmacy (retail and mail order) copays do not apply toward the out-of-pocket maximum		
Other Services								
Allergy testing	$10 copay Allergy Serum: No charge	$30 copay Allergy Serum: No charge	$40 copay Allergy Serum: You pay 40% copay	$20 copay Allergy Serum: You pay 40% copay	You pay 20% (deductible does not apply) Allergy Serum: 20% after CY deductible	You pay 30% after CY deductible	Allergy serum: $10 copay	Allergy serum: $5 copay
Chiropractic care	Not covered Discount program available	Not covered Discount program available	Not covered Discount program available	Not covered Discount program available	20% after CY deductible up to 30 visits per calendar year combined PPO/Non-PPO maximum	30% after CY deductible up to 30 visits per calendar year combined PPO/Non-PPO maximum	Not covered	Not covered
Durable medical equipment (DME) Breast Pump Orthotic Equipment/devices Prosthetic Equipment	No charge	Not covered	DME: You pay 40% No charge No charge No charge	DME: You pay 40% No charge No charge No charge	You pay 20% after CY deductible Breast Pump: No charge	You pay 30% after CY deductible Breast Pump: Not covered	No charge	You pay 50%
Physical and Occupational Therapy	Office Location: $10 copay Outpatient Dept. of a Hospital: No charge	Office Location: $30 copay (up to 12 visits per calendar year Outpatient Dept. of	$40 copay	$20 copay	You pay 20% (deductible does not apply)	You pay 30% after CY deductible	$10 copay	$40 copay

		a Hospital: Not covered						
Speech Therapy	Office Location: $10 copay Outpatient Dept. of a Hospital: No charge	Office Location: $30 copay Outpatient Dept. of a Hospital: Not covered	$40 copay	$20 copay	You pay 20% (deductible does not apply)	You pay 30% after CY deductible	$10 copay	$40 copay
Vision (exam only)	$10 copay (one exam in a consecutive 12-month period provided through contracted VPA)	$0 up to $60/year plus 100% of additional charges (one exam in a consecutive 12-month period provided through contracted VPA)	(Not covered)	(Not covered)	You pay 20% self-referred exam per 12 consecutive months, no age limit (Vision plan administrator's providers only)	You pay 20% self-referred exam per 12 consecutive months, no age limit (Vision plan administrator's providers only)	No charge	No charge
Travel								
Network (For urgent care services)	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Shield Global Core Program Refer to your EOC	Kaiser facilities in the US. Claim forms required for Out of Area Urgent and ER care	Kaiser facilities in the US. Claim forms required for Out of Area Urgent and ER care
Immunizations for purposes of Foreign Travel	$10 copay/injection	$30 copay/injection	$10 copay/injection	$10 copay/injection	You pay 20% after CY deductible	You pay 30% after CY deductible	No charge	No charge
Additional Travel Information	provider.bcbs.com bcbsglobalcore.com	provider.bcbs.com bcbsglobalcore.com	provider.bcbs.com bcbsglobalcore.com	provider.bcbs.com bcbsglobalcore.com	provider.bcbs.com bcbsglobalcore.com	provider.bcbs.com bcbsglobalcore.com	kp.org (search for "Travel Health")	kp.org (search for "Travel Health")

Note! This is a Brief Comparison. Please refer to the Healthplan's Evidence of Coverage or Summary of Benefits for a detailed description of coverage, limitations and exclusions.