CALIFORNIA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION

Blue Shield HMO Plans
VICTOR VALLEY COLLEGE

BENEFITS	HMO Plan 1C (Access+ and Trio Networks)		HMO Plan 9 (Access+ and Trio Networks)	
Annual Deductible (per calendar year):				
Individual / Family	None		$1,000/$2,000	
Maximum Out of Pocket (per calendar year):				
Individual / Family	$500/$1,500		$3,500/$7,000	
Professional Services				
Office Visit /Specialist	$10/$10 visit		$25/$25 visit	
Specialist (Self-Referral in Medical Group)	$20/visit		$40/visit	
Teladoc Visit	Access+ - $5 Copay	Trio - $0 Copay	Access+ - $5 Copay	Trio - $ Copay
Urgent Care	$10/visit		$25/visit	
Preventative Care	No copay		No copay	
Hospital Medical Services				
Physician Services	No copay		No copay	
Hospital Facility	No copay		No copay	
Outpatient Services				
Outpatient Surgery Facility	No copay		No copay	
Lab and X-Ray	No copay		No copay	
Advanced Imaging (MRI, CT, PET)	No copay		$100/visit	
Chiropractic and Acupuncture (30 visits per year combined)	$10 Copay		$10 Copay	
Durable Medical Equipment	No copay		50%	
Emergency				
Emergency Services Copay	$50/visit		$150/visit	
Ambulance Services Copay	No copay		$100/trip	
Mental Health and Substance Abuse				
Inpatient (Physician visit)	No copay		No copay	
Inpatient (Facility-based care)	No copay		No copay	
Outpatient (Physician visit)	$10/visit		$25/visit	
Outpatient (Facility-based care)	No copay		No copay	
Pharmacy Benefits	**Access +**	**Trio**	**Access +**	**Trio**
Tier 1 (30 Day)	$5 Copay	Level A - $0 Copay Level B - $5 Copay	$5 Copay	Level A - $0 Copay Level B - $5 Copay
Tier 2 (30 Day)	$10 Copay	Level A - $5 Copay Level B - $10 Copay	$20 Copay	Level A - $10 Copay Level B - $20 Copay
Tier 3 (30 Day)	$25 Copay	Covered with Prior Authorization	$35 Copay	Covered with Prior Authorization
Specialty (30 Day)	$25 Copay	$10 Copay	$35 Copay	$20 Copay
Mail Order (90 Day)	2x Retail	2x Retail	2x Retail	2x Retail

Kaiser HMO Plan
VICTOR VALLEY COLLEGE

BENEFITS	Kaiser HMO Plan 10 w/ Optical
Annual Deductible (per calendar year)	
Annual Deductible (per calendar year)	None
Maximum Out of Pocket (per calendar year)	
Individual/Family	$1,500/$3,000
Professional Services	
Office Visit Copay/Specialist	$10/visit
Specialist (Self-Referral in Medical Group)	N/A
Telehealth Visits	No copay
Preventive	No copay
Urgent Care	$10/visit
Hospital Medical Services	
Inpatient Services	No copay
Hospital Facility	No copay
Outpatient Services	
Outpatient Surgery & Supplies	$10/procedure
X-Rays and Lab Tests (when performed in non-hospital based facility)	No copay
Advanced Imaging (MRI, CT, PET)	No copay
Chiropractic and Acupuncture (30 visits per year combined)	$10 Chiro; $10 Acupuncture
Durable Medical Equipment	No copay
Emergency	
Ambulance Services	No copay
Emergency Services Copay	$50 copay
Mental Health and Substance Abuse	
Inpatient Hospital Physician	No copay
Outpatient Visits	$10/visit
Inpatient Hospital Services	No copay
Optical Benefit	
Benefit Allowance Amount	150 Allowance
Prescription Drug Copay	
Tier 1 - Generic Formulary	$5 copay (100 day)
Tier 2 - Brand Formulary	$5 copay (100 day)
Tier 3 - Non-Formulary	Only covered with prior authorization
Tier 4 - Specialty	$5 copay (30 day)
Mail Order	Match retail

For Summary Illustration and Comparison Purposes Only. Please refer to each company's plan documents to verify eligibility, benefits and conditions for coverage. This summary illustration and comparison is NOT to be relied upon, and is NOT binding as to the Company's benefits.

CALIFORNIA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION

Blue Shield PPO Plans
VICTOR VALLEY COLLEGE

BENEFITS	PPO 1 (Full & Tandem) Participating PPO/Non-Participating PPO	
Annual Deductible (per calendar year):		
Individual / Family	$200/$400	
Maximum Out of Pocket (per calendar year):		
Individual / Family	$2,000/$4,000 (participating) $5,000/$10,000 (non-participating)	
Professional Services		
Coinsurance	10% / 30%	
Office Visit	$10 / 30%	
Teladoc Visit	Full - $5 / Not Covered	Tandem - $0 / Not Covered
Urgent Care	$10 /30%	
Preventative Care	No copay / 30%	
Hospital Medical Services		
Physician Services	10% / 30%	
Hospital Facility	10% / 30% up to $600/day + 100% of additional charges	
Outpatient Services		
Outpatient Surgery Facility	10% / 30% (up to $350 max per day)	
Lab and X-Ray	10% / 30% (up to $350 max per day)	
Advanced Imaging (MRI, CT, PET)	10% / 30% (up to $350 max per day)	
Chiropractic Services (limited to 24 visits per calendar year)	$10 / 30%	
Acupuncture - Services for disease, illness or injury (limited to 12 visits per calendar year)	10% / 30%	
Durable Medical Equipment	10% / 30%	
Emergency Services Copay	10% / 10%	
Ambulance Services Copay	20% / 20%	
Mental Health and Substance Abuse		
Inpatient (Physician visit)	10% / 30%	
Inpatient (Facility-based care)	10% / 30% of up to $600/day + 100% of additional charges	
Outpatient (Physician visit)	$10 / 30%	
Outpatient (Facility-based care)	10% / 30% (up to $350 max per day)	
Pharmacy Benefits	**Full PPO**	**Tandem PPO**
	Plus Formulary	**Value Formulary**
Value-Based Tier Drugs	Not Covered	$0 Copay/Not Covered Deductible Does Not Apply
Tier 1 (30 Day)	$5 Copay/25% + $5/prescription	Level A - $0 Copay/25% +$5/prescription Level B - $5 Copay/25% + $5/prescription
Tier 2 (30 Day)	$10 Copay/25% + $10/prescription	Level A - $5 Copay/25% + $10/prescription Level B - $10 Copay/25% + $10/prescription
Tier 3 (30 Day)	$25 Copay/25% + $25/prescription	$25 Copay/25% + $25/prescription
Tier 4 (30 Day)	$25 Copay/25% + $25prescription	$25 Copay/25% + $25/prescription
Mail Order (90 Day)	2x Retail/Not Covered	2x Retail/Not Covered

Note: All PPO plans have Tandem network with the same benefits except for Rx formulary.

For Summary Illustration and Comparison Purposes Only. Please refer to each company's plan documents to verify eligibility, benefits and conditions for coverage. This summary illustration and comparison is NOT to be relied upon, and is NOT binding as to the Company's benefits.