

Ventura County Community College District

Medical Plan Comparison

ALL ELIGIBLE FACULTY MEMBERS

Effective 1/1/2008

| BENEFITS | BLUE CROSS (PPO) | | HEALTH NET (HMO) | KAISER (HMO) |
|---|--|---|---|--------------------------------------|
| | IN-NETWORK | OUT-OF-NETWORK | | |
| Lifetime Maximum | \$5,000,000 | | Unlimited | Unlimited |
| Calendar Year Deductible Individual Family | \$200 \$600 (exceptions may apply; please refer to EOC for details) | | Not Applicable | Not Applicable |
| Calendar Year Out-of-Pocket Maximum | \$1,500 (plus deductible and certain copayments) | \$3,000 (plus deductible, certain copayments and amounts over covered expenses) | Individual \$1,500 Two-Party \$3,000 Family \$4,500 | Individual \$1,500 Family \$3,000 |
| Physician Services Office Visit Laboratory & X-rays Prenatal & Postnatal Care | 80% of negotiated rates 100% of negotiated rates 100% of negotiated rates | 60% of covered expenses 80% of covered expenses 70% of covered expenses | No copay No copay No copay | No copay No copay No copay |
| Well Baby Care (under age 7) Routine Physicals Immunizations | \$25 copay per visit (deductible waived) 100% of negotiated rates (deductible waived) | 80% of covered expenses Blue Cross maximum payment of \$20 per visit 80% of covered expenses Blue Cross maximum payment of \$12 per immunization | No copay No copay | No copay No copay |
| Preventive Care (age 7 and over) Routine Physicals | 100% of negotiated rates (deductible waived) | 100% of covered expenses | No copay | No copay |
| Adult Preventive Services | 100% of negotiated rates (deductible waived) | 100% of covered expenses (deductible waived) | No copay | No copay |

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|--|---|--|------------------------------------|--|
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| Hospitalization Services Semi-private room and board | 100% of negotiated rates | 70% of covered expenses | No copay | No copay |
| Emergency Room | 100% of negotiated rates | 80% (no copay for true emergencies) | \$35 copay (waived if admitted) | No copay |
| Outpatient Surgery/Treatment Ambulatory Surgery Center | 100% of negotiated rates | 70% of covered expenses (benefit limited to \$350/day) | No copay | Not covered |
| Ambulance | 100% | 100% | No copay | No copay |
| Home Health Care | 80% of negotiated rates | 60% of covered expenses | \$10 copay | No copay |
| Hospice Care | 100% of negotiated rates (deductible does not apply) | 100% of covered expenses (deductible does not apply) | No copay | No copay |
| Skilled Nursing Facility (SNF) | 100% of negotiated rates | 70% of covered expenses | No copay | No Copay (Inside service area; limited to 100 days) |
| Durable Medical Equipment | 80% | 80% of covered expenses | No copay | No copay |
| Mental Health ** Inpatient (non-severe conditions) | 100% of negotiated rates | 70% of covered expenses (up to 30 days per calendar year) | No copay | No copay (up to 45 days per calendar year) |
| Outpatient (non-severe conditions) | 80% of negotiated rates (up to \$75 per visit) | 60% of covered expenses (up to \$25 per visit) | No copay | No copay |

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|------------------------------|---|--|-----------------------------|--|
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| Substance Abuse** | | | | |
| Inpatient | 100% of negotiated rates | 70% of covered expenses (up to 30 days per calendar year which does not apply to detox during acute phase) | No copay | No copay (Inpatient detoxification) |
| Outpatient visits | 80% of negotiated rates (up to \$75 per visit) | 60% of covered expenses (up to \$25 per visit) | \$20 individual; \$10 group | No copay |
| Prescription Drug | | | | |
| Prescription Drug Deductible | \$50 per member (separate from medical deductible) | | Not Applicable | Not Applicable |
| Retail: | | | | |
| Generic | \$10 copay | \$10 copay plus 50% of the remaining prescription drug covered expense | \$5 copay | \$5 copay |
| Brand | (When no generic equivalent is available or prescriber states "dispense as written") | | (Formulary) | (Formulary) |
| | \$30 copay | \$30 copay plus 50% of the remaining prescription drug covered expense | \$10 copay | \$10 copay |
| | (When a generic equivalent is available or prescriber has not specified "dispense as written") | | (Non-Formulary) | (Non-Formulary) |
| | \$30 copay plus the difference of prescription drug covered expense between the generic and brand drug | \$30 copay plus 50% of the remaining prescription drug covered expense and the difference of prescription drug covered expense between the generic and brand drug | \$35 copay | \$10 copay |
| | (up to 30 day supply) | | (up to 30 day supply) | (up to 100 day supply) |

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|---|---|----------------|---|------------------------|
| | IN-NETWORK | OUT-OF-NETWORK | | |
| Prescription Drug Mail Order: Your Calendar Year Out of Pocket Maximum | \$500 Individual \$1,000 Family (excluding the deductible) | Not Applicable | Not Applicable | Not Applicable |
| Generic | \$20 copay | Not Covered | \$10 copay | \$5 copay |
| Brand | (When no generic equivalent is available or prescriber states "dispense as written") | | (Formulary) | \$10 copay |
| | \$60 copay | Not Covered | \$20 copay | |
| | (When a generic equivalent is available or prescriber has not specified "dispense as written") | | (Non-Formulary) | |
| | \$60 copay plus the difference of prescription drug covered expense between the generic and brand drug (up to 90 day supply) | Not Covered | \$70 copay (up to 90 day supply) | (up to 100 day supply) |

** Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. Severe mental disorders include schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia and serious emotional disturbances of children.

This is a summary only. Please refer to the actual EOCs for complete details.