Keenan & Associates

Ventura County Community College

Summary of PPO & HMO Plans

Effective Date	**7/1/2018**	**7/1/2018**
Renewal Date	**7/1/2019**	**7/1/2019**
Carrier Name	**Anthem Blue Cross**	**Kaiser Permanente Insurance Company**
Plan Name	**PPO**	**HMO**
Eligible Class	**Faculty**	**Faculty**

	In-Network Benefits	Out-of-Network Benefits	Schedule of Benefits
General Plan Information			
Annual Deductible/Individual		$200	N/A
Annual Deductible/Family		$600	N/A
Coinsurance	80%	60-80% see plan certificate	N/A
Office Visit/Exam	80%	60%	$15 copay
Outpatient Specialist Visit	80%	60%	$15 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$1,500
Annual Out-of-Pocket Limit/Family	$4,500	$9,000	$3,000
Deductible Included in Out-of-Pocket Limits	No	No	N/A
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required			Yes
Outpatient Services			
Preventive Services			
Well-Child Care (birth through age six)	$25 copay (deductible waived)	80% (benefit limited to $20/exam)	100% through age 23 months
Routine Physical Examinations and Immunizations (age 7 and older)	100% (deductible waived)	100%	100%
Immunizations (birth through age six)	100% (deductible waived)	80% (benefit limited to $12/immunization)	100%
Well Woman Exams	100% (deductible waived)	100% (deductible waived)	100%
Mammograms	100% (deductible waived)	100% (deductible waived)	100%
Adult Periodic Exams with Preventive Tests	100% (deductible waived)	100% (deductible waived)	100%
Diagnostic X-Ray and Lab Tests	100%	80%	100%
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal Care)	100%	70%	100%
Inpatient Hospital Services			
Inpatient Hospitalization	100%	70%; additional 25% penalty applied*	100%
Pre-Authorization of Services Required	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	70%	100%
Surgical Services			
Outpatient Facility Charge	100%	70% (limited to $350/day for ambulatory surgical center)	$15 copay per procedure
Emergency Services			
Emergency Room	100%	100%	$50 copay waived if admitted
Ambulance			
Air	100%	100%	
Ground	100%	100%	$50 copay per trip
Urgent Care			
Urgent Care Facility	80%	60%	$15 copay per visit
Mental Health Benefits			
Inpatient Care	100%	70%	100%
Outpatient Care	80%	60%	$15 copay per individual visit; $7 copay per group visit
Substance Abuse			
Inpatient Care			
Inpatient Hospitalization	100%	70%	100%
Inpatient Detoxification Services			100%
Outpatient Care			
Outpatient Services	80%	60%	$15 copay per individual visit; $5 copay per group visit

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	In-Network Benefits	Out-of-Network Benefits	Schedule of Benefits
Prescription Drug Benefits			
Prescription Drug Deductible		$50 per member	N/A
Generic	$10 copay	$10 copay plus 50% of the drug max allowed amt. & costs in excess of the drug max. allowed amt.	$5 copay
Brand (Formulary/Preferred)	$30 copay	$30 copay plus 50% of the drug max allowed amt. & costs in excess of the drug max. allowed amt.	$10 copay
Brand (Non-Formulary/Non-preferred)	$30 copay	$30 copay plus 50% of the drug max allowed amt. & costs in excess of the drug max. allowed amt.	$10 copay
Number of Days Supply	30 days	30 days	Up to a 100-day supply
Mail Order			
Generic	$20 copay	Not covered	$5 copay
Brand (Formulary/Preferred)	$60 copay	Not covered	$10 copay
Brand (Non-Formulary/Non-preferred)	$60 copay	Not covered	Not covered
Number of Days Supply for Mail Order	90 days	90 days	Up to a 100-day supply
Other Services and Supplies			
Durable Medical Equipment & Prosthetic Devices	80%	80%	100%
Home Health Care	80% (not covered while member receives hospice care)	60% (not covered while member receives hospice care)	100% up to 100 visits per calendar year
Skilled Nursing or Extended Care Facility	100%	70%	100% up to 100 days per benefit period
Hospice Care	100% (deductible waived)	100% (deductible waived)	100%
Chiropractic Services	80%	60%	Not covered
Acupuncture	Not covered	Not covered	Not covered
Vision			
Annual Allowance Amount	N/A	N/A	$150 Allowance Every 24 Months
Examination	N/A	N/A	100% exams for refraction
Hearing			
Screening	80%	80%	100%
Aid(s)	80%	80%	Not covered
Infertility			
Diagnosis	Not covered	Not covered	Not covered
Treatment	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services			
Physical	80%	60%	$15 copay
Occupational	80%	60%	$15 copay
Speech	80% (Outpatient speech therapy following injury or organic disease)	60% (Outpatient speech therapy following injury or organic disease)	$15 copay

* For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for hospital services and supplies is reduced by 25%, resulting in higher costs for members.