CVT KAISER HEALTH PLANS
ANTELOPE VALLEY COLLEGE – CERTIFICATED
October 1, 2014 – September 30, 2015

BENEFIT	KAISER 1	KAISER 3 w/CHIRO	KAISER 7	KAISER 8 Deductible Plan
Calendar Year Deductible	$0	$0	$0	Individual: $1,000 Family: $2,000
Coinsurance	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance & medical copays)	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000
Doctor Visits	$10 Copay	$20 Copay	$35 Copay	$20 Copay, No Deductible
Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*, No Deductible
Preventive Care for Children	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*, No Deductible
Preventive Care for Adults	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*, No Deductible
Outpatient X-ray and Lab	Paid at 100%*	Paid at 100%*	Paid at 100%*	$10 Copay, No Deductible
Radiation Therapy, Chemotherapy	Radiation Therapy: Paid at 100%* Chemotherapy: $10 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $20 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $35 Copay	Radiation Therapy: Paid at 100% after Deductible is met Chemotherapy: Paid at 100%, No Deductible
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 80%	Paid at 80%, No Deductible
Ambulance – Ground/Air	Paid at 100%* If Med. Necessary	Paid at 100%* If Med. Necessary	$100 Per Trip If Med. Necessary	$150 Per Trip, No Deductible, If Med. Necessary
Physical Therapy	$10 Copay	$20 Copay	$35 Copay	$20 Copay, No Deductible

Page 2	KAISER 1	KAISER 3 w/CHIRO	KAISER 7	KAISER 8 Deductible Plan
Chiropractic	Not Covered	Chiro Benefit Offered through ChiroMetrics: $10 Office Visit Copay: $15 Daily Maximum for Out of Network; Up to 40 Visits Per Year – After 12th Visit Must be Precertified.	Not Covered	Not Covered
Acupuncture	$10 Copay Referral by Plan Physician	$20 Copay Referral by Plan Physician	$35 Copay Referral by Plan Physician	$20 Copay, No Deductible Referral by Plan Physician
Hospital Inpatient	Paid at 100%*	Paid at 100%*	$250 Copay	Paid at 80% after Deductible is met
Hospital Emergency Room	$35 Copay Copay waived if admitted as in-patient	$50 Copay Copay waived if admitted as in-patient	$100 Copay Copay waived if admitted as in-patient	Paid at 80% after Deductible is met
Home Health Care	Paid at 100%*(Limits)	Paid at 100%*(Limits)	Paid at 100%*(Limits)	Paid at 100%*,No Deductible (Limits)
Hospice	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*, No Deductible
Prescription Drugs	**Retail** $5 Generic $10 Brand (Up to 30 Day Supply) $10 Generic $20 Brand (31- 60 Day Supply) $15 Generic $30 Brand (61-100 Day Supply) **Mail Order** $5 Generic $10 Brand (30 Day Supply) $10 Generic $20 Brand (31-100 Day Supply)	**Retail** $10 Generic $20 Brand (Up to 30 Day Supply) $20 Generic $40 Brand (31- 60 Day Supply) $30 Generic $60 Brand (61-100 Day Supply) **Mail Order** $10 Generic $20 Brand (30 Day Supply) $20 Generic $40 Brand (31-100 Day Supply)	**Retail** $10 Generic $30 Brand (Up to 30 Day Supply) $20 Generic $60 Brand (31- 60 Day Supply) $30 Generic $90 Brand (61-100 Day Supply) **Mail Order** $10 Generic $30 Brand (30 Day Supply) $20 Generic $60 Brand (31-100 Day Supply)	**Retail** $10 Generic $30 Brand (Up to 30 Day Supply) $20 Generic $60 Brand (31- 60 Day Supply) $30 Generic $90 Brand (61-100 Day Supply) **Mail Order** $10 Generic $30 Brand (30 Day Supply) $20 Generic $60 Brand (31-100 Day Supply)

*** For Covered Expenses Only**

NOTES: COPAYS FOR INFERTILITY: Plans 1 – $10 Copay; Plans 3, 7, 8 – 50% Copay.
COPAYS FOR ALLERGY INJECTIONS: Plans 1 & 3 – No Charge; Plan 7 - $5 Per Visit; Plan 8 – No Charge

THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.