



College of the Desert
CSEA

2023-2024	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Kaiser
	100-D \$20	100-G \$20	90-G \$20	80-E \$20	10-0	Trad HMO \$20
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$300/\$600	\$500/\$1,000	\$500/\$1,000	\$300/\$600	\$0/\$0	\$0
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$2,000	\$1,500/\$3,000

PROFESSIONAL SERVICES

Office Visit (OV) co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$20	\$20	\$20	\$20	\$10	\$20
Urgent Care co-pay	\$20	\$20	\$20	\$20	\$10	\$20
Specialists/Consultants co-pay	\$20	\$20	\$20	\$20	\$10	\$20
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$20	\$0	\$0
Scans: CT, CAT, MRI, PET etc.	0%	0%	10%	20%	\$0	\$0
Diagnostic X-ray & Laboratory Procedures	0%	0%	10%	20%	\$0	\$0
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered	50%	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	\$0	\$0

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (copay waived if admitted)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	\$100	\$100
Inpatient Hospital (preauthorization required) - limits may apply	0%	0%	10%	20%	\$0	\$0
Outpatient Hospital	0%	0%	10%	20%	\$0	\$20
Surgery, Outpatient (performed in Surgery Center)	0%	0%	10%	20%	\$0	\$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	0%	10%	20%	\$0	\$20

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	\$0	\$0
OUTPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	\$10	\$20

OTHER SERVICES

Ambulance (Ground or Air)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	\$100	\$50
Acupuncture - Limits apply	0%	0%	10%	20%	\$10/30 visits combined w/chiro	\$10/30 visits (through ASH) combined w/chiro
Chiropractic - Limits apply	0%	0%	10%	20%	\$10/30 visits combined w/acu	\$10/30 visits (through ASH) combined w/acu
Durable Medical Equipment (DME)	0%	0%	10%	20%	0%	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	10%	20%	\$10	\$20
Hearing Aids	Amount in excess of \$700 allowance/24 months	Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months	50% Coinsurance 1 device/24 months	amount in excess of \$500 allowance every 36 months

PHARMACY BENEFITS

Plan	9-35	200/10-35	200/10-35	200/10-35	200/10-35	Trad HMO \$20
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	\$200/\$500	\$200/\$500	\$200/\$500	\$200/\$500	none
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$2,500/\$3,500	\$2,500/\$3,500	\$2,500/\$3,500	\$2,500/\$3,500	\$2,500/\$3,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	\$0 at Costco	\$0 at Costco	\$0 at Costco	\$0 at Costco	\$0 at Costco	\$10 up to 100 day
Brand co-pay/30 days supply	\$35	\$35.00	\$35.00	\$35.00	\$35.00	\$20 up to 100 day
Specialty co-pay/up to 30 days supply	\$35 Must Use	\$35 Must Use	\$35 Must Use	\$35 Must Use	\$35 Must Use	\$20 up to 30 day
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$90	\$0-\$90	\$10-\$20/up to 100 day supply
Mail Order Pharmacy	Costco Mail Order	Costco Mail Order	Costco Mail Order	Costco Mail Order	Costco Mail Order	Kaiser Mail Order

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.