

255 Stanley Avenue, Suite 100
Ventura, California 93001
T 805.641.5000
www.venturausd.org



For the future of every student

TO:

DATE:

RE: VOLUNTARY SELF-PAY RETIREE PLAN

Attached is the information from the California Schools Employee Benefits Organization (CSEBO) regarding the Voluntary Self-Pay Retiree Plan offered to individuals retiring with the Ventura Unified School District and STRS or PERS.

If you are interested in continuing your health coverage with California Schools Employee Benefits Organization (CSEBO), please complete and return to the California Schools Employee Benefits Organization (CSEBO) the following attached forms no later than **thirty days before your** Ventura Unified School District Health and Welfare Active Employee Health and Welfare Benefits terminate:

- Ventura Unified School District Voluntary Self-Pay Retiree Enrollment form
- Applicant Acknowledgements
- If enrolling in Anthem PPO Medical Plan: Applicant Acknowledgements and Agreements-Anthem Blue Cross Members
- If enrolling in Kaiser HMO: Kaiser Foundation Health Plan Arbitration Agreement
- **If enrolling in Kaiser HMO and you or your dependents are over 65:** Please contact Risk Management/Insurance for a Kaiser Permanente Senior Advantage (KPSA) Group Plan Enrollment form

When electing medical coverage, CSEBO requires participation in Medicare A and B upon reaching age 65. Please submit a copy of your Medicare card to CSEBO indicating the start date for Medicare A and B.

A retiree may choose the level of health coverage for themselves and their dependents who are currently covered under Active Employee Health and Welfare Benefits. If choosing medical coverage when you first enroll in the Voluntary Self-Pay Retiree Plan, you may remain with your current medical plan or change to another medical plan within the Voluntary Self-Pay Retiree Plan. You may change between the CSEBO Anthem PPO Plan IV and the Kaiser HMO plans during Open Enrollment which occurs every October, with an effective start date of January 1st.

Feel free to contact Jodie Argueta, Risk Management Specialist at 805-641-5000 x 1242 with any questions you may have.

IMPORTANT NOTICE REGARDING VOLUNTARY SELF-PAY RETIREE BENEFITS

California Schools Employee Benefits Organization (CSEBO) provides a Voluntary Self-Pay Retiree Health Plan ("Plan"). The following requirements and rules apply to the Voluntary Self-Pay Retiree Plan:

1. Participants must have or purchase Medicare Parts A and B if they are age 65 or older. Retirees and dependents under age 65 who are disabled must also purchase Medicare Parts A and B. If you don't enroll in Medicare when you are first eligible, you may have to pay a late enrollment penalty if you decide you want Medicare later.
2. Retirees must meet the requirements for Retiree status under STRS/PERS and/or your District rules.
3. Coverage must be continuous. This means that the Voluntary Self-Pay Retiree Plan coverage option must be elected within 30 days of the day 1) you retire or 2) your District Paid coverage ends, if applicable.
4. Participants must disclose any other health plan that may exist for which they are eligible to receive benefits in order for CSEBO to coordinate benefits.
5. CSEBO has full and exclusive authority to modify or terminate the Voluntary Self-Pay Retiree Plan, establish self-pay rates and/or change carriers and health care providers at its discretion. CSEBO is not required to provide benefits for Retirees for life or any other guaranteed period. CSEBO's modification and/or termination of the Retiree Plan is independent of any right or claim to health insurance that a Retiree may have or assert against his or her former employer. In addition, CSEBO may terminate the Plan in its entirety by providing 30 days' notice to the Plan participants.
6. Any Retiree who elects to participate in the Voluntary Self-Pay Retiree Plan and subsequently drops coverage will not be allowed to resume coverage under any other medical, dental, or vision plan offered by CSEBO.
7. CSEBO will determine the amount of monthly self-pay premiums required for coverage under this Plan. Self-payments must be remitted to the designated agent of CSEBO by the due date as determined by CSEBO.
8. Retirees who have been participating in the dental and vision programs as active employees under the provisions of their respective school districts may continue to do so. However, you must elect this coverage immediately upon retirement. Once you have dropped dental and vision coverage, you will be prohibited from electing this coverage in the future.
9. Retirees may not add dependents who were not previously covered, and your dependents may not enroll in additional coverage if not previously covered.

Please review the summary of benefits and current rate schedule attached to this notice.
Should you decide to participate in the Voluntary Self-Pay Retiree Plan, please complete and return the election notice.

California Schools Employee Benefits Organization
Renewal Rates Effective January 1, 2026, Through December 31, 2026
Ventura Unified School District

<u>Eligibility</u>	<u>Coverage</u>	<u>Vendor</u>	<u>Plan</u>	<u>Tier</u>	<u>Rate Basis</u>	<u>CSEBO Billed Premium</u>
Self-Pay Retirees	Medical	Anthem	Indemnity IV PPO (Under 65) ¹	Single	Monthly	\$ 2,026.92
				Two-Party		\$ 3,886.14
				Family		\$ 5,058.34
			Indemnity IV PPO (Over 65 with A&B) ¹	Single	Monthly	\$ 1,437.57
				Two-Party		\$ 2,717.21
				Family		\$ 3,892.65
		Kaiser	Indemnity IV PPO (One Over 65 & One Under 65) ¹	Two-Party	Monthly	\$ 3,301.67
				Family		\$ 4,605.75
			CDHP PPO 90 (Under 65)	Single	Monthly	\$ 1,338.37
				Two-Party		\$ 2,399.84
				Family		\$ 3,268.48
	Dental	Delta Dental	PPO ³	Single	Monthly	\$ 72.67
				Two-Party		\$ 130.65
				Family		\$ 202.86
	Vision	VSP	Base	Single	Monthly	\$ 8.23
				Two-Party		\$ 14.88
				Family		\$ 23.02
			Buy-Up	Single	Monthly	\$ 13.93
				Two-Party		\$ 25.21
				Family		\$ 39.00

¹Includes \$20K lifetime maximum infertility benefits, 50% coinsurance, in and out of network.

²Includes chiropractic and acupuncture rider.

³Based on In-Network/Out-of-Network annual maximum of \$2,500 with incentive levels of 70/80/90/100, implant coverage, night guards, and 2 cleanings per year.

Ventura Unified School District
VOLUNTARY SELF-PAY RETIREE ENROLLMENT FORM
 EFFECTIVE DATE: _____

Email this completed form to: aragatz@ycoe.org
 Or mail this completed form to: **CSEBO**
5189A Verdugo Way
Camarillo, CA 93012

EMPLOYEE INFORMATION				
Last Name	First Name	MI	Date of Birth	Social Security Number
Street Address	City	State	ZIP	Phone Number
				() -
Email: _____			Date of Retirement: _____	
Sex: ☐ M ☐ F				
EMPLOYEE BENEFIT SELECTION – PLEASE SELECT YOUR PLAN				
Kaiser Traditional HMO 30 Plan:		☐ HMO 30 (Under 65)		
Single		☐ \$1,236.50 Monthly		
Two-Party		☐ \$2,473.00 Monthly		
Family		☐ \$3,499.30 Monthly		
Kaiser DHMO CDHP 90 Plan:		☐ DHMO CDHP 90 (Under 65)		
Single		☐ \$969.26 Monthly		
Two-Party		☐ \$1,935.23 Monthly		
Family		☐ \$2,736.97 Monthly		
Kaiser Senior Advantage Plan:		☐ \$25 Copay Senior Advantage Plan (With Medicare A&B)		
Per Retiree		☐ \$183.99 Monthly		
Anthem Blue Cross Indemnity IV PPO Plan:		☐ Indemnity IV PPO (Under 65)		
Single		☐ \$2,026.92 Monthly		
Two-Party		☐ \$3,886.14 Monthly		
Family		☐ \$5,058.34 Monthly		
Anthem Blue Cross Indemnity IV PPO Plan:		☐ Indemnity IV PPO (Over 65 with Medicare A&B)		
Single		☐ \$1,437.57 Monthly		
Two-Party		☐ \$2,717.21 Monthly		
Family		☐ \$3,892.65 Monthly		
Anthem Blue Cross Indemnity IV PPO Plan		☐ Indemnity IV PPO (One Over 65 & One Under 65)		
Two-Party		☐ \$3,301.67 Monthly		
Family		☐ \$4,605.75 Monthly		
Anthem Blue Cross CDHP PPO 90 Plan:		☐ CDHP PPO 90 (Under 65)		
Single		☐ \$1,338.37 Monthly		
Two-Party		☐ \$2,399.84 Monthly		
Family		☐ \$3,268.48 Monthly		
Delta Dental		☐ PPO		
Single		☐ \$72.67 Monthly		
Two-Party		☐ \$130.65 Monthly		
Family		☐ \$202.86 Monthly		
Vision:		☐ Base		☐ Buy-Up
Single		☐ \$8.23 Monthly		☐ \$13.93 Monthly
Two-Party		☐ \$14.88 Monthly		☐ \$25.21 Monthly
Family		☐ \$23.02 Monthly		☐ \$39.00 Monthly

MEDICAL, DENTAL, AND VISION ENROLLMENT/CHANGE FORM

FAMILY INFORMATION

Please list any eligible dependents you wish to enroll in your plans. Please provide all the information requested for each individual you are enrolling.

Name (First, M.I., Last)	Relationship :	Sex:	Date of Birth:	Social Security Number:	Full time Student?	IRS Dependent?	Enroll In:
	☐ Spouse/ Domestic Partner ☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision
	☐ Child	☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision

Disclosure

Signature Required on Arbitration Disclosure – Read Carefully

APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

ANTHEM BLUE CROSS MEMBERS

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits HIV tests from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature Required for Anthem Blue Cross HMO and PPO Plans

Date

Print Employee Name

Disclosure

**KAISER FOUNDATION HEALTH PLAN
MEMBERS**

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature Required for Kaiser Permanente Plans

Date

Print Employee Name

APPLICANT ACKNOWLEDGEMENTS

I acknowledge that the above represents my enrollment choices. I understand that by signing this form I am waiving or authorizing payroll deductions for any required contributions for the coverage(s) selected on the previous page.

I understand that my elections cannot be changed or cancelled until a future open enrollment period or a qualified status change occurs, i.e., marriage, registered domestic partnership, divorce, dissolution of registered domestic partnership, birth, adoption, legal guardianship, legal custody, or a change in eligibility of a child to age 26.

Appropriate documentation must be provided for all covered dependents at the time of enrollment and/or qualified event status changes, i.e., birth, adoption/guardianship/custody, marriage, domestic partner declaration, divorce, death to age 26.

I represent to the best of my knowledge and belief, all statements and answers entered into this application are true, complete and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void and that I will be responsible for reimbursement of all claims paid for myself or my dependents during an ineligible period.

By signing this form I acknowledge that personal and health information contained in this application will be exchanged in the course of this transaction and going forward in the administration of my Health Plan Benefits.

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions of this form. A reproduction of this authorization shall be as valid as the original.

Employee Signature: _____ Date: _____

Employee Name: (Please Print) _____

**BY SIGNING THIS DOCUMENT, I HAVE READ
& ACKNOWLEDGE THE BENEFIT
MATERIALS GIVEN TO ME.**

Employee Name: (Please Print) _____ Date: _____

Employee Signature: _____

CARRIER		INDEMNITY IV PPO		CDHP PPO 90		HMO 30		CDHP DHMO 90	
PLAN NAME		IN-NETWORK		OUT-OF-NETWORK ¹		IN-NETWORK ONLY		IN-NETWORK ONLY	
GENERAL PLAN INFORMATION		IN-NETWORK		OUT-OF-NETWORK ¹		IN-NETWORK ONLY		IN-NETWORK ONLY	
Annual Medical Out-of-Pocket Limit									
Individual/Individual in Family/Family		\$2,000/\$2,000/\$4,000 ²		Unlimited		\$3,000/\$6,000/\$6,000 (Combined Medical & Rx Out-of-Pocket Max)		Unlimited	
Individual/Individual in Family/Family		\$800/\$800/\$2,400 ²		\$800/\$800/\$2,400 ²		\$1,700/\$3,400/\$3,400 (Combined Medical & Rx Deductible)		\$4,000/\$8,000/\$8,000 (Combined Medical & Rx Deductible)	
Annual Medical Deductible - Plan Deductible Applies Unless Otherwise Stated									
Plan Information									
Type of Plan		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)	
Referrals Required?		No		No		No		Yes	
Plan Coinsurance		Plan Pays 85% (After Deductible)		Plan Pays 50% Coinsurance (After Deductible)		Plan Pays 90% (After Deductible)		Plan Pays 50% Coinsurance (After Deductible)	
Health Savings Account (HSA) Compatibility:									
HSA-Compatible Plan?		No		No		Yes		No	
2026 Individual Maximum Contribution		N/A		N/A		\$4,400		N/A	
2026 Family Maximum Contribution		N/A		N/A		\$8,750		N/A	
Over 55 HSA Contribution Catch-Up		N/A		N/A		\$1,000		N/A	
Physician/Diagnostic Services									
Preventive Care		No Charge		Not Covered		No Charge		Not Covered	
Primary Care Office Visit		15% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)	
Specialist Office Visit		15% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)	
Diagnostic X-Ray and Lab Tests		15% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)	
Advanced Imaging (MRI/PET/CAT Scans)		15% Coinsurance (After Deductible)		50% Coinsurance (After Deductible) up to \$800 per Procedure Maximum		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible) up to \$800 per Procedure Maximum	
Inpatient Hospital Services									
Inpatient Hospitalization		15% ⁴ Coinsurance (After Deductible)		50% Coinsurance (After Deductible) ⁴ up to \$1,000 Maximum per Day		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible) up to \$1,000 Maximum per Day	
Outpatient Services									
Outpatient Surgery		15% ⁴ Coinsurance (After Deductible)		50% Coinsurance (After Deductible) ⁴ up to \$350 per Day Maximum		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible) up to \$350 per Day Maximum	
Outpatient Lab and Imaging		15% ⁴ Coinsurance (After Deductible)		50% Coinsurance (After Deductible) ⁴ up to \$350 per Procedure Maximum		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible) up to \$350 per Procedure Maximum	
Emergency Services									
Ambulance Services		15% Coinsurance (After Deductible)		15% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	
Emergency Room		15% Coinsurance (After Deductible)		15% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)	
Urgent Care									
Urgent Care Visits		15% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)		10% Coinsurance (After Deductible)		50% Coinsurance (After Deductible)	

¹When using out-of-network providers, you are responsible for the deductible, coinsurance, and additional amounts exceeding the usual and customary charges.

²For Anthem Indemnity IV PPO: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

³The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to per person out-of-pocket maximum. In addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.

⁴\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

CARRIER	INDEMNITY IV PPO	CDHP PPO 90	HMO 30	CDHP DHMO 90
PLAN NAME	In-Network	Out-of-Network	In-Network Only	In-Network Only
Mental Health and Substance Abuse				
Inpatient Mental Health	15% ⁴ Coinsurance (After Deductible) up to \$1,000 per Day Maximum	50% ⁴ Coinsurance (After Deductible) up to \$1,000 per Day Maximum	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible) up to \$1,000 per Day Maximum
Outpatient Mental Health Office Visit	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Other Outpatient Health Services	15% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible)	50% Coinsurance (After Deductible)
Other Services				
Acupuncture	15% Coinsurance (After Deductible), Maximum of 18 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible)	10% Coinsurance (After Deductible), Maximum of 20 visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Chiropractor Services	\$20 Copay (Deductible Waived), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Hearing Aids	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Infertility Diagnosis & Treatment	\$20K Lifetime Maximum, 50% Coinsurance	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Prescription Drug Out-of-Pocket Limit	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Individual/Individual in Family/Family	\$20K Lifetime Maximum, 50% Coinsurance	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Prescription Drug Deductible	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Per Individual	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Prescription Drug Formulary	\$20K Lifetime Maximum, 50% Coinsurance	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Fomulary (Covered Drugs)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Retail	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Generic	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Brand (Formulary/Preferred)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Brand (Non-Formulary/Non-Preferred)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Mail Order	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Generic	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Brand (Formulary/Preferred)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Brand (Non-Formulary/Non-Preferred)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%
Specialty Rx (Specialty Pharmacy Only; 30-day supply)	\$500 Maximum Benefit per Ear, Every 12 Months	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%	10% Coinsurance (After Deductible), Maximum of 30 Visits per Calendar Year, Then Plan Pays 0%	50% Coinsurance (After Deductible), Maximum of 6 Visits per Calendar Year, Then Plan Pays 0%

¹For Anthem Indemnity IV PPO: The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

²\$250 deductible applies if utilization review is not obtained (waived for emergency admissions and outpatient freestanding surgery centers).

Note: This summary of benefits is a brief outline of coverage designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC) will prevail.

To access the Uniform Glossary of Health Coverage and Medical Terms, please visit: <http://www.csebo.net/Resources/Uniform-Glossary>.

CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2026 - 12/31/2026



PLAN NAME		DELTA DENTAL PPO ¹	
GENERAL PLAN INFORMATION		DELTA DENTAL PPO PROVIDERS ¹	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Calendar Year Annual Maximum		\$2,500	\$2,500
Incentive Levels			
Percentage level increases 10% for each consecutive year the dentist is visited, to a maximum of 100%.		70/80/90/100%	70/80/90/100%
Diagnostic and Preventive Benefits		Incentive Level Coverage	
Prophylaxis (Cleaning) Treatments Oral Examinations Full-Mouth X-Rays Bitewing X-Rays Periodontal Scaling and Root Planing Fluoride Treatments Space Maintainers		Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²
		Plan Pays 100%; limited to 2 per calendar year ²	Plan Pays 100%; limited to 2 per calendar year ²
		Plan Pays 100%; limited to 1 per 36 months ²	Plan Pays 100%; limited to 1 per 36 months ²
		Plan Pays 100%; upon provider request, maximum of 2 per calendar year ²	Plan Pays 100%; upon provider request, maximum of 2 per calendar year ²
		Plan Pays 100%; limited to 1 each quadrant every 24 months	Plan Pays 100%; limited to 1 each quadrant every 24 months
		Plan Pays 100% limited to 4 per calendar year. ²	Plan Pays 100% limited to 4 per calendar year. ²
Basic Benefits		Incentive Level Coverage	
Oral Surgery - Extractions Oral Surgery - Other Surgical Procedures		Plan Pays 70/80/90/100%; limited to once per tooth per lifetime	Plan Pays 70/80/90/100%; limited to once per tooth per lifetime
		Plan Pays 50-100% depending on procedure	Plan Pays 50-100% depending on procedure

CSEBO DENTAL INSURANCE
DELTA DENTAL PPO
EFFECTIVE 1/1/2026 - 12/31/2026



PLAN NAME		DELTA DENTAL PPO ¹	
GENERAL PLAN INFORMATION		DELTA DENTAL PPO PROVIDERS ¹	PREMIER & NON-DELTA DENTAL PPO PROVIDERS
Basic Benefits (continued)		Incentive Level Coverage	
Restorative Procedures - Amalgam, Silicate or Composite (Resin) Restorations (Fillings)		Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period	Plan Pays 70/80/90/100%; limited to once per surface, per tooth within a 2 year period
	Endodontic Treatments	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply
	Periodontic Treatment	Plan Pays 70/80/90/100%; limitations apply	Plan Pays 70/80/90/100%; limitations apply
	Sealants	Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.	Plan Pays 70/80/90/100%; limited to once per tooth within 3 year period, up to age 14.
Crowns, Inlays, Onlays and Cast Restoration Benefits		Incentive Level Coverage	
Crowns, Inlays, Onlays and Cast Restoration		Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years	Plan Pays 70/80/90/100%; service on the same tooth only once every 5 years
Prosthodontic Benefits		Incentive Level Coverage	
Implants		Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
	Removable - Partial Dentures, Full Dentures	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
	Fixed - Inlays, Onlays, Bridges	Plan Pays 50%; limited to once every 5 years	Plan Pays 50%; limited to once every 5 years
Nightguards		Incentive Level Coverage	
Coverage Percentage		Plan Pays 100%; limited to once per lifetime	Plan Pays 100%; limited to once per lifetime
Lifetime Individual Maximum		\$500	\$500
Orthodontia Benefits		Incentive Level Coverage	
Coverage Eligibility		Not Covered	Not Covered

¹Reimbursement to providers is based on the PPO contracted fee for PPO dentists. Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

²2 cleanings, Exams and X-ray costs do not count towards the calendar year annual maximum.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

To access the Uniform Glossary of Health Coverage and Medical Terms, please visit: <http://www.csebo.net/Resources/Uniform-Glossary>.

CSEBO VISION INSURANCE
VSP PPO COMPARISON
EFFECTIVE 1/1/2026 - 12/31/2026



GENERAL PLAN INFORMATION			BASE		ENHANCED BUY-UP	
Service Frequencies	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam Every Lenses Every Frame Every	12 Months 12 Months 24 Months	12 Months 12 Months 24 Months	12 Months 12 Months 24 Months	12 Months 12 Months 24 Months	12 Months 12 Months 12 Months	12 Months 12 Months 12 Months
Benefits						
Copays	\$10	\$10	\$10	\$10	\$10	\$10
Examination	Covered After Copay	Up To \$45	Up To \$45	Up To \$45	Covered After Copay	Up To \$45
Contact Lens Fitting	Covered After Copay	Up To \$45	Up To \$45	Up To \$45	Covered After Copay	Up To \$45
Retinal Imaging	Up to \$39, After \$10 Copay	Up To \$45	Up To \$45	Up To \$45	Covered After Copay	Up To \$45
Prescription Glasses						
Coverage	Contacts <u>OR</u> Glasses	Contacts <u>OR</u> Glasses	Contacts <u>OR</u> Glasses	Contacts <u>OR</u> Glasses	Contacts <u>AND</u> Glasses	Contacts <u>AND</u> Glasses
Frame Allowance	\$200	Up To \$70	Up To \$70	Up To \$70	\$300	Up To \$70
Elective Contact Allowance	\$200	Up To \$90	Up To \$90	Up To \$90	\$300	Up To \$105
Lenses						
Single Vision	Covered After Copay	Up To \$30	Up To \$30	Up To \$30	Covered After Copay	Up To \$30
Lined Bifocal	Covered After Copay	Up To \$50	Up To \$50	Up To \$50	Covered After Copay	Up To \$50
Lined Trifocal	Covered After Copay	Up To \$65	Up To \$65	Up To \$65	Covered After Copay	Up To \$65
Lense Enhancements (Negotiated Member Share Savings of 20-25%)¹						
Anti-Reflective Coatings	\$41 - \$85	Provider Rate	Provider Rate	Provider Rate	\$40 copay ²	Provider Rate
Custom Progressive Lenses	\$150 - \$175	Provider Rate	Provider Rate	Provider Rate	\$150 - \$175	Provider Rate
Edge Polish	\$36	Provider Rate	Provider Rate	Provider Rate	\$36	Provider Rate
Light Filler	\$15	Provider Rate	Provider Rate	Provider Rate	\$15	Provider Rate
High Index Lenses	\$50 - \$125	Provider Rate	Provider Rate	Provider Rate	\$50 - \$125	Provider Rate
Light-Reactive Lenses	\$75	Provider Rate	Provider Rate	Provider Rate	\$75	Provider Rate
Polarized Lenses	\$57 - \$101	Provider Rate	Provider Rate	Provider Rate	\$57 - \$101	Provider Rate
Impact-Resistant Lenses	\$35	Provider Rate	Provider Rate	Provider Rate	\$35	Provider Rate
Premium Progressive Lenses	\$95 - \$105	Provider Rate	Provider Rate	Provider Rate	\$95 - \$105	Provider Rate
Scratch-Resistant Coating	\$17 - \$33	Provider Rate	Provider Rate	Provider Rate	\$17 - \$33	Provider Rate
Standard Progressive Lenses	No Charge	Provider Rate	Provider Rate	Provider Rate	No Charge	Provider Rate
Tinted (Colored) Lenses	\$15 - \$17	Provider Rate	Provider Rate	Provider Rate	\$15 - \$17	Provider Rate
UV Protection	\$16	Provider Rate	Provider Rate	Provider Rate	\$16	Provider Rate

¹ Costco Optical pricing already includes member savings.

² Costco Optical pricing may vary.

Note: This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

To access the Uniform Glossary of Health Coverage and Medical Terms, please visit: <http://www.csebo.net/Resources/Uniform-Glossary>.



California Schools Employee Benefits Organization

5189A Verdugo Way Camarillo, CA 93012
(805) 383-1969 | FAX: (805) 383-1971
www.csebo.net

May 16, 2023

OPEN ENROLLMENT PACKET

WHCRA ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your Summary Plan Description (SPD) or full Evidence of Coverage (EOC) for your specific plan's deductible and coinsurance. If you would like more information on WHCRA benefits, call your plan administrator or Member Services.

CSEBO
5189A Verdugo Way
Camarillo, CA 93012
Phone: (805) 383-9388
www.csebo.net

HIPAA PRIVACY REMINDER

California Schools Employee Benefits Organization ("CSEBO", the "Plan") is committed to maintaining the confidentiality of your private medical information. CSEBO maintains a full Notice that describes our efforts to safeguard your health information from improper or unnecessary use or disclosure of your privacy rights. We are providing this abbreviated Notice to you because privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, CFR Parts 160 and 164 ("HIPAA"), require the plan to provide you with a summary of the Plan's privacy practices and related legal duties, and your rights

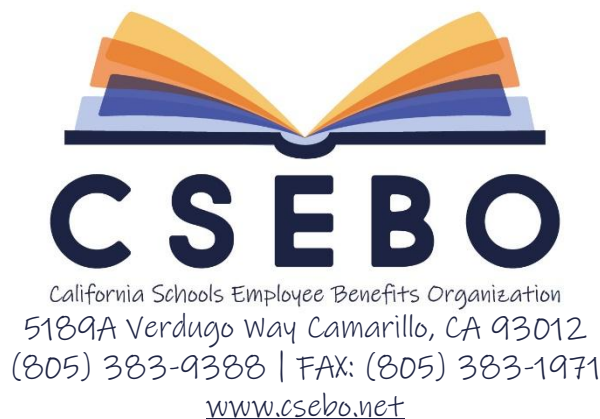
The Anthem HMO and Kaiser HMO's generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem HMO and Kaiser HMO designates one for you. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider, and for a list of participating primary care providers, contact the following:

Anthem Blue Cross
HMO Member Services: 1-800-227-3771
www.anthem.com

Kaiser Permanente
HMO Member Services: 1-800-464-4000
www.kp.org

You do not need prior authorization from the Anthem HMO or Kaiser HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem HMO or Kaiser HMO listed above.



Paying Monthly Premiums Frequently Asked Questions

How do I pay my monthly premiums?

Monthly premiums will be paid through CSEBO's E-Bill Express Payment website using the following link: <https://www.e-billexpress.com/ebpp/CSEBO>

When will invoices be available to pay on E-Bill Express?

Invoices will be available to pay around the 5th of each month.

When are invoices due?

Invoices are due on the last business day of each month.

What happens if I don't pay my invoice by the due date?

If payment is not received, CSEBO will make multiple attempts to contact you via email, phone, and mail. If we do not receive a response or payment after these attempts, your coverage will be cancelled effective the first day of the month for which payment was due.

Can I pay by ACH, credit card, or debit card?

Yes, payments can be made by electronic check (ACH), credit or debit card. Please note, there is a fee of approximately 3.8% for paying by credit or debit card.

Can I pay my invoice by mailing a check?

No. Payments can only be made using the E-Bill Express payment portal.

Can I set up recurring payments?

Yes, there is an option available on the E-Bill Express payment portal to set up recurring payments. The payments will process automatically on the last business day of each month. The date that the payment processes cannot be changed.

What is my Login ID?

Your Login ID is your last name plus the last 4 digits of your Social Security Number. For example, if an employee name is Jane Doe, SSN 333-33-3336, the Login ID would be Doe3336.

What if I get locked out of my account?

Please contact CSEBO by emailing ARagatz@vcoe.org or calling (805) 383-9388 to unlock your account.



California Schools Employee Benefits Organization
5189A Verdugo Way Camarillo, CA 93012
(805) 383-9388 | FAX: (805) 383-1971
www.csebo.net

E-Bill Express Payment Instructions

Premiums are due on the last business day of each month. If payment is not made by the due date, coverage will be cancelled as of the first day of the month for which the payment was due.

To pay your monthly premiums, please go to CSEBO's E-Bill Express Payment website by using this link: <https://www.e-billexpress.com/ebpp/CSEBO/>

How to Make a Payment

LOGIN ID: Last name + last 4 digits of Social Security Number

YOUR ID:

*For example, if an employee name is Jane Doe, SSN 333-33-3336, the **Login ID** would be: Doe3336*

To Enroll or Make a Guest Payment, you will need to enter your **Login ID** and your **Postal Code**.

*For example, if employee Jane Doe wants to **Enroll** or make a **Guest Payment**, the login would look like this:*

LOGIN	GUEST PAYMENT	Welcome to
* Required Fields		
* ID		
Doe3336		
* Postal		
93010		
		

CSEBO's E-Bill Express Payment Instructions

After you successfully enter the E-Bill Express payment website by entering your **Login ID** and **Postal Code**, you will see the screen below:

Required Fields

Pay My Bills

Due Date ▾

UNPAID AND PARTIALLY PAID ▾

HISTORY

[Hide Account Groupings](#) [Export](#)

	Invoice Date	Due Date	Amount Due	Payment Amount	
▾	ID Ragatz1234 Arumda Ragatz				
▾	4/12/2023	4/28/2023	1,123.93	1,123.93	☒ <input type="button" value="Magnifying Glass"/>

Check this box to select the invoice you want to make a payment on.

Click the Magnifying Glass to view the detailed invoice

MESSAGES

Please contact us at 805-383-9388 or ARagatz@vcoe.org if you have any questions

PAYMENT SUMMARY

1 Invoice \$1,123.93
Total Payment [Calculate](#)
[Remove All](#)

* Payment Method

* Pay Date 5/11/2023

Payments confirmed before Thursday, May 11, 2023 5:00 PM PST will be posted on Thursday, May 11, 2023. Payments confirmed after Thursday, May 11, 2023 5:00 PM PST will be posted on Thursday, May 11, 2023.

Once you click **Add** to add a **Payment Method**, you will be given the option to enter your **Bank Account** information or **Credit/Debit Card** information. Please note, if paying by credit card, an additional service fee will may apply :

Add A Payment Method

Choose your preferred payment method to pay your bills.

* Required Fields

 **BANK ACCOUNT**

 **CREDIT CARD**

Enter your **Bank Account** information or **Credit/Debit Card** information and click **Add**:


CREDIT CARD

* Give This Account a Nickname

* Country

United States

* City

Camarillo

* Full Name on Card

Amanda Ragatz

* Address

104 Cambridge Dr

* State

CA - California

* Card Number






Address2

* Postal

93603

* Expiration Date

01/12 - 12/12

* Security Code

123 456

By continuing this action, you authorize the information you've provided on the above account to be used for creation of a charge to the account listed above. You also affirm that the information you provided is correct, that you are a signer on the account above and there are available funds to cover the amount of any transactions that you authorize.

Add


BANK ACCOUNT

* Account Type

Personal

Business

* Account #

* Banking Type

Checking Account

Savings Account

* Re-enter Account #

* Give This Account a Nickname

Pay to the Order of

* Name on the Account

Amanda Ragatz

123456789

000123456789

1111

Routing Number

Account Number

* Routing Number

Make sure to use your bank account number; not your ATM or Debit card number.

By continuing this action, you authorize the information you've provided on the above account to be used for creation of a charge to the account listed above. You also affirm that the information you provided is correct, that you are a signer on the account above and there are available funds to cover the amount of any transactions that you authorize.

Add

Once the Payment is made, you will receive payment Confirmation.

After you click **Make Payment**, you will receive Confirmation that your payment has been made. On this screen, you can Print the **Confirmation** or **Set Up AutoPay** recurring payments.

Confirmation

Thank You! Your payment has been made.

 [Print Confirmation Page](#)



**Click here to Print
Confirmation Page**

Payment Date 5/11/2023

Payment Method Jane's Bank WELLS FARGO
BANK NA *****0019

Total Payment \$1,123.93

Payments confirmed before Thursday, May 11, 2023 5:00 PM PST will be posted on Thursday, May 11, 2023.
Payments confirmed after Thursday, May 11, 2023 5:00 PM PST will be posted on Thursday, May 11, 2023.

If you have any further questions about payments to CSEBO, please contact our office at 805-383-1969 .

ID	Confirmation #	Payment Amount
	3100199453	\$1,123.93

[Set Up AutoPay](#)

[Return to Pay My Bills](#)

[Log Out](#)



**Click here to Set Up
AutoPay Recurring
Payments**

If you have additional questions on how to make a payment using
CSEBO's E-Bill Express website, please contact CSEBO at:

ARagatz@vcoe.org or (805) 383-9388