Preferred Provider Organization (PPO) Plan Summaries
Anthem Blue Cross

October 1, 2019 through September 30, 2020

CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

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100% PPO PLAN OPTIONS 2019 / 2020			
SERVICES	**PPO PLAN 1**	**PPO PLAN 2**	**PPO PLAN 3**
CALENDAR YEAR DEDUCTIBLE	$0		$100 Ind. / $200 Family
COINSURANCE	Paid at 100%		Paid at 100% after deductible is met
CALENDAR YEAR OUT OF POCKET MAX (medical and pharmacy combined)	Individual: $1,250 / Family: $2,500		
DOCTOR VISITS – Primary and Specialist	$10 Copay	$20 Copay	
URGENT CARE	$10 Copay	$20 Copay	
TELEHEALTH THROUGH MDLIVE	$5 copay for non-emergency medical and dermatology conditions, $10 copay for Behavioral Health	$5 copay for non-emergency medical and dermatology conditions, $20 copay for Behavioral Health	
PREVENTIVE CARE AND IMMUNIZATIONS	Paid at 100%; Covered, if eligible		
OUTPATIENT DIAGNOSTIC TESTS	**Non-Hospital** - Paid at 100% **Hospital** - $50 copay, then paid at 100%		**Non-Hospital** - Paid at 100% after deductible is met **Hospital** - $50 copay, then paid at 100% after deductible is met
OUTPATIENT IMAGING	**Non-Hospital** - Paid at 100% **Hospital** - $75 copay, then paid at 100%		**Non-Hospital** - Paid at 100% after deductible is met **Hospital** - $75 copay, then paid at 100% after deductible is met
DURABLE MEDICAL EQUIPMENT	Paid at 100%		Paid at 100% after deductible
AMBULANCE-GROUND/AIR	100% of covered charges		100% of covered charges after deductible
PHYSICAL THERAPY AND CHIROPRACTIC *Non-participating providers limited to a combined maximum 13 visits per year*	Paid at 100% (Copay, if applicable)		Paid at 100% after deductible (Copay, if applicable)
ACUPUNCTURE Maximum of 12 visits per year	Paid at 100% (Copay, if applicable)		Paid at 100% after deductible (Copay, if applicable)
OUTPATIENT SURGERY	**Non-Hospital** - Paid at 100% **Hospital** - $250 copay, then paid at 100%		**Non-Hospital** - Paid at 100% after deductible is met **Hospital** - $250 copay, then paid at 100% after deductible is met
HOSPITAL INPATIENT Unlimited days; semiprivate room	Paid at 100%		Paid at 100% after Deductible
HOSPITAL EMERGENCY ROOM Copay waived if admitted as in-patient; if admitted paid at 100% after deductible	$100 Emergent Copay; / $175 Non-Emergent Copay		

Prescription Benefit Options		RX A	RX B	RX C	RX D	RX V
An RX plan must be paired with each PPO Plan	**Retail** **30-Day Supply**	$5 Generic $22 Brand	$7 Generic $15 Preferred $30 Non-Preferred	$7 Generic $25 Preferred $40 Non-Preferred	$150 Brand Deductible	$150 Brand Deductible
					$10 Generic $40 Preferred $100 Non-Preferred	$0 Generic $30 Brand
	Mail Order **90-Day Supply**	$10 Generic $44 Brand	$15 Generic $35 Preferred $70 Non-Preferred	$15 Generic $60 Preferred $90 Non-Preferred	$25 Generic $100 Preferred $250 Non-Preferred	$0 Generic $60 Brand

For Covered Expenses Only: When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible & percentage copay. All percentages are based on payments to preferred hospitals, Physicians and other network providers.

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90% PPO PLAN OPTIONS 2019 / 2020			
SERVICES	**PPO PLAN 4**	**PPO PLAN 5**	**PPO WELLNESS PLAN WITH RX PLAN C**
CALENDAR YEAR DEDUCTIBLE	Individual: $100 / Family: $200		Individual: $500 / Family: $1,000
COINSURANCE	Paid at 90% after deductible is met		
CALENDAR YEAR OUT OF POCKET MAX (medical and pharmacy combined)	Individual: $1,250 / Family: $2,500		Individual: $1,750 / Family: $3,500
DOCTOR VISITS – Primary and Specialist	$20 Copay	$30 Copay	$20 Primary / $40 Specialist
URGENT CARE	$20 Copay	$30 Copay	$20 Copay
TELEHEALTH THROUGH MDLIVE	$5 copay for non-emergency medical and dermatology conditions, $20 copay for Behavioral Health	$5 copay for non-emergency medical and dermatology conditions, $30 copay for Behavioral Health	$5 copay for non-emergency medical and dermatology conditions, $40 copay for Behavioral Health
PREVENTIVE CARE AND IMMUNIZATIONS	Paid at 100%; Covered, if eligible		
OUTPATIENT DIAGNOSTIC TESTS	**Non-Hospital** - Paid at 90% after deductible is met / **Hospital** - $50 copay, then paid at 90% after deductible is met		
OUTPATIENT IMAGING	**Non-Hospital**- Paid at 90% after deductible is met / **Hospital** - $75 copay, then paid at 90% after deductible is met		
DURABLE MEDICAL EQUIPMENT	Paid 90% after deductible		
AMBULANCE-GROUND/AIR	Paid 90% after deductible		
PHYSICAL THERAPY AND CHIROPRACTIC *Non-participating providers limited to a combined maximum 13 visits per year*	Paid at 90% after deductible (Copay if applicable)		
ACUPUNCTURE Maximum of 12 visits per year	Paid at 90% after deductible (Copay if applicable)		
OUTPATIENT SURGERY	**Non-Hospital** - Paid at 90% after deductible is met / **Hospital** - $250 copay, then paid at 90% after deductible is met		
HOSPITAL INPATIENT Unlimited days; semiprivate room	Paid at 90% after deductible		
HOSPITAL EMERGENCY ROOM Copay waived if admitted as in-patient; if admitted paid at 90% after deductible	$100 Emergent Copay / $175 Non-Emergent Copay		

Prescription Benefit Options		RX A	RX B	RX C	RX D	RX V
An RX plan must be paired with each PPO Plan	**Retail 30-Day Supply**	$5 Generic $22 Brand	$7 Generic $15 Preferred $30 Non-Preferred	$7 Generic $25 Preferred $40 Non-Preferred	$150 Brand Deductible	$150 Brand Deductible
					$10 Generic $40 Preferred $100 Non-Preferred	$0 Generic $30 Brand
	Mail Order 90-Day Supply	$10 Generic $44 Brand	$15 Generic $35 Preferred $70 Non-Preferred	$15 Generic $60 Preferred $90 Non-Preferred	$25 Generic $100 Preferred $250 Non-Preferred	$0 Generic $60 Brand

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80% PPO PLAN OPTIONS 2019 / 2020					
SERVICES	**PPO PLAN 6**	**PPO PLAN 7**	**PPO PLAN 8**	**PLAN 9**	**PLAN 10**
CALENDAR YEAR DEDUCTIBLE	Individual: $250 Family: $500		Individual: $500 Family: $1,000	Individual: $1,000 Family: $2,000	Individual: $2,000 Family: $4,000
COINSURANCE	Paid at 80% after deductible is met				
CALENDAR YEAR OUT OF POCKET MAX (medical and pharmacy combined)	Individual: $2,000 Family: $4,000		Individual: $3,250 Family: $6,500	Individual: $5,000 Family: $10,000	Individual: $6,350 Family: $12,700
DOCTOR VISITS – Primary and Specialist	$20 Copay	$30 Copay		$35 Copay	Paid at 80% after deductible
TELEHEALTH THROUGH MDLIVE	$5 copay for non-emergency medical and dermatology conditions, $20 copay for Behavioral Health	$5 copay for non-emergency medical and dermatology conditions, $30 copay for Behavioral Health		$5 copay for non-emergency medical and dermatology conditions, $35 copay for Behavioral Health	$5 copay for non-emergency medical and dermatology conditions, 80% after deductible for Behavioral Health
PREVENTIVE CARE AND IMMUNIZATIONS	Paid at 100%; Covered, if eligible				
OUTPATIENT DIAGNOSTIC TESTS	**Non-Hospital** - Paid at 80% after deductible is met / **Hospital** - $50 copay, then paid at 80% after deductible is met				
OUTPATIENT IMAGING	**Non-Hospital** - Paid at 80% after deductible is met / **Hospital** - $75 copay, then paid at 80%				
DURABLE MEDICAL EQUIPMENT	Paid at 80% after deductible				
AMBULANCE-GROUND/AIR	Paid at 80% after deductible				
PHYSICAL THERAPY AND CHIROPRACTIC *Non-participating providers limited to a combined maximum 13 visits per year*	Paid at 80% after deductible (Copay if applicable)				Paid at 80% after deductible
ACUPUNCTURE Maximum of 12 visits per year	Paid at 80% after deductible (Copay if applicable)				Paid at 80% after deductible
OUTPATIENT SURGER	**Non-Hospital** - Paid at 80% after deductible is met / **Hospital** - $250 copay, then paid at 80% after deductible is met				
HOSPITAL INPATIENT Unlimited days; semiprivate room	Paid at 80% after deductible				
HOSPITAL EMERGENCY ROOM Copay waived if admitted as in-patient; if admitted paid at 80% after deductible	$100 Emergent Copay; / $175 Non-Emergent Copay				

Prescription Benefit Options		RX A	RX B	RX C	RX D	RX V
An RX plan must be paired with each PPO Plan	**Retail** **30-Day Supply**	$5 Generic $22 Brand	$7 Generic $15 Preferred $30 Non-Preferred	$7 Generic $25 Preferred $40 Non-Preferred	$150 Brand Deductible $10 Generic $40 Preferred $100 Non-Preferred	$150 Brand Deductible $0 Generic $30 Brand
	Mail Order **90-Day Supply**	$10 Generic $44 Brand	$15 Generic $35 Preferred $70 Non-Preferred	$15 Generic $60 Preferred $90 Non-Preferred	$25 Generic $100 Preferred $250 Non-Preferred	$0 Generic $60 Brand

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CVT Bronze Plan and High Deductible Health Plans (HDHP) 2019 / 2020

SERVICES	CVT Bronze Plan NOT HSA Compatible	High Deductible Health Plan-1 (HSA)	High Deductible Health Plan-2 (HSA)	High Deductible Health Plan-3 (HSA)
CALENDAR YEAR DEDUCTIBLE	Individual: $5,000 Family: $10,000	Individual: $1,350 Family: $2,700 (No individual limit applies to family)	Individual: $2,000 Family: $4,000 (No individual limit applies to family)	Individual: $1,500 Family: $3,000 (No individual limit applies to family)
COINSURANCE	70% after deductible	90% after deductible	80% after deductible	60% after deductible
CALENDAR YEAR OUT OF POCKET MAX (medical and pharmacy combined)	Individual $6,350 Family $12,700	Individual: $4,250 Family: $8,500 Family = Employee with 1 or more covered dependents. No one individual will pay more than $7,150.	Individual: $5,250 Family: $10,500 Family = Employee with 1 or more covered dependents. No one individual will pay more than $7,150.	Individual: $6,250 Family: $12,500 Family = Employee with 1 or more covered dependents. No one individual will pay more than $7,150.
DOCTOR VISITS	**Primary Care Physician** - First 3 visits covered in full after $60 copay per visit; Remaining visits - Paid at 70% after deductible is met **Specialty Physician** - Subject to deductible then $70 copay	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
TELEHEALTH THROUGH MDLIVE	$5 copay for non-emergency medical and dermatology conditions, $70 copay after deductible is met for Behavioral Health	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
PREVENTIVE CARE AND IMMUNIZATIONS	Paid at 100%; Covered, if eligible	Paid at 100%; Covered, if eligible	Paid at 100%; Covered, if eligible	Paid at 100%; Covered, if eligible
OUTPATIENT DIAGNOSTIC TESTS	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
OUTPATIENT IMAGING	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
DURABLE MEDICAL EQUIPMENT	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
AMBULANCE-GROUND/AIR	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
PHYSICAL THERAPY AND CHIROPRACTIC *Non-participating providers limited to a combined maximum 13 visits per year*	Paid at 70% after deductible (Copay if applicable)	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
ACUPUNCTURE Maximum of 12 visits per year	Paid at 70% after deductible (Copay if applicable)	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
OUTPATIENT SURGERY	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
HOSPITAL INPATIENT Unlimited days; semiprivate room	Paid at 70% after deductible	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
HOSPITAL EMERGENCY ROOM	Subject to deductible, then $250 Copay	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
Prescription Benefits	**Bronze Plan RX Benefit**	**HDHP 1 RX Benefits**	**HDHP 2 RX Benefits**	**HDHP 3 RX Benefits**
Retail **30-Day Supply**	Subject to deductible, then $25 Copay Generic $50 Copay Brand	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible
Mail Order **90-Day Supply**	Subject to deductible, then $50 Copay Generic $100 Copay Brand	Paid at 90% after deductible	Paid at 80% after deductible	Paid at 60% after deductible

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