# California's Valued Trust (CVT): Plan 5B

**Coverage Period: 10/01/2016 – 09/30/2017**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual+Spouse, Family|**Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cvtrust.org or by calling 1-800-288-9870.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $100 Individual/$300 Family | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes<br>Individual: $1,250<br>Family: $3,750 | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, health care this plan does not cover, pharmacy copayments for members enrolled in Medicare Part D prescription benefits | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, for a list of preferred providers, see www.anthem.com/ca or call 1-800-234-4333 and www.caremark.com or call 1-888-354-6390. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-234-4333 or visit us at www.anthem.com/ca or www.caremark.com or call 1-888-354-6390.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cvtrust.org or call 1-800-288-9870 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30/visit | $30/visit | You may be responsible for paying additional non-participating provider charges.<br><br>For non-emergency medical issues, call MDLIVE to provide you with 24/7/365 access to board-certified doctors by online video, phone or secure email for $5.00 copay. 1-888-632-2738 or mdlive.com/cvt |
| | Specialist visit | $30/visit | $30/visit | |
| | Other practitioner office visit | $30/visit | $30/visit | |
| | Preventive care/screening/immunization | No charge | No charge | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. Pre-authorization required. |
| | Imaging (CT/PET scans, MRIs) | 10% co-insurance | 10% co-insurance | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.cvtrust.org. | Generic drugs | $7 copay /prescription at retail; $15 copay / prescription at mail order | 100% up-front cost; paper claim may be submitted to request partial reimbursement | Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription) |
| | Preferred brand drugs | $15 copay / prescription at retail; $35 copay / prescription at mail order | 100% up-front cost; paper claim may be submitted to request partial reimbursement | Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription). The out of pocket amount will increase if a brand drug is dispensed when there is a generic available. You will pay the generic copay, plus the cost difference between the generic and brand drug. |
| | Non-preferred brand drugs | $30 copay / prescription at retail; $70 copay / prescription at mail order | 100% up-front cost; paper claim may be submitted to request partial reimbursement | Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription). The out of pocket amount will increase if a brand drug is dispensed when there is a generic available. You will pay the generic copay, plus the cost difference between the generic and brand drug. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Specialty drugs | Specialty copayments follow the tier structure above. Specialty medications utilize a separate network that can be found at www.caremark.com | 100% up-front cost; paper claim may be submitted to request partial reimbursement. Not payable if not filled through Caremark's separate specialty network | Covers up to a 30 day supply. An evaluation will be conducted for specialty medications to determine if the drugs prescribed meet defined clinical criteria and to ensure the appropriateness of your prescribed drug. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. |
| | Physician/surgeon fees | 10% co-insurance | 10% co-insurance | |
| **If you need immediate medical attention** | Emergency room services | $100/visit, plus 10% co-insurance | $100/visit, plus 10% co-insurance | |
| | Emergency medical transportation | 10% co-insurance | 10% co-insurance | |
| | Urgent care | $30/visit | $30/visit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. Pre-authorization required.<br><br>Reference Based Benefits (RBB) program provides a set benefit maximum for Hip Replacement, Knee Replacement, Hysterectomy, and Laminectomy surgeries under the Anthem Blue Cross Plans. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Physician/surgeon fee | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $30/visit and 10% co-insurance for other outpatient services | $30/visit and 10% co-insurance for other outpatient services | You may be responsible for paying additional non-participating provider charges.<br><br>Pre-authorization is required for in-patient services.<br><br>For non-emergency medical issues, call MDLIVE to provide you with 24/7/365 access to licensed therapists by online video, phone or secure email for $5.00 copay. 1-888-632-2738 or mdlive.com/cvt |
| | Mental/Behavioral health inpatient services | 10% co-insurance | 10% co-insurance | |
| | Substance use disorder outpatient services | $30/visit and 10% co-insurance for other outpatient services | $30/visit and 10% co-insurance for other outpatient services | |
| | Substance use disorder inpatient services | 10% co-insurance | 10% co-insurance | |
| **If you are pregnant** | Prenatal and postnatal care | $30/visit and 10% co-insurance for other maternity services | $30/visit and 10% co-insurance for other maternity services | You may be responsible for paying additional non-participating provider charges. |
| | Delivery and all inpatient services | 10% co-insurance | 10% co-insurance | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. Coverage is limited to 100 visits per calendar year. Pre-authorization is required. |
| | Rehabilitation services | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. |
| | Habilitation services | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. See Evidence of Coverage booklet for details and descriptions. |
| | Skilled nursing care | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. Coverage is limited to 100 days for a Skilled nursing facility. Pre-authorization is required. |
| | Durable medical equipment | 10% co-insurance | 10% co-insurance | You may be responsible for paying additional non-participating provider charges. Pre-authorization is required for amounts above $1,000. |
| | Hospice service | No charge | No charge | You may be responsible for paying additional non-participating provider charges. |
| **If your child needs dental or eye care** | Eye exam | No Charge | No Charge | Limited to the eye exam portion of a preventive visit. You may have other vision coverage not described here. |
| | Glasses | Not covered | Not covered | You may have other vision coverage not described here. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Dental check-up | Not covered | Not covered | You may have other dental coverage not described here. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-288-9870. You may also contact your state insurance department or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Your plan at 1-800-288-9870; the California Department of Insurance at 1-800-927-4357 (Calling from within CA), 1-213-897-8921 (Outside California), 1-800-482-4833 (TDD – Telecommunication Devices for the Deaf). Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed Health Care Help Center at 1-888-466-2219 or www.healthhelp.ca.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-288-9870.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,560
- **Patient pays** $980

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $100 |
| Copays | $10 |
| Coinsurance | $720 |
| Limits or exclusions | $150 |
| **Total** | **$980** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,510
- **Patient pays** $890

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays (for medical coverage):**

| | |
|---|---|
| Deductibles | $100 |
| Copays | $580 |
| Coinsurance | $130 |
| Limits or exclusions | $80 |
| **Total** | **$890** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.