Pg 1 Plan Name is **MUSD Employees** **REVISED Eff 10/01/2013** **$2000/yr Dental Max with all plans** **$10.00 Vision Co pay with all plans** **Dist Pays $1484.30**	Anthem Plan **1**/Prescription **A** (Health $1209.00 Dental $125.19 Vision $19.80 per month) **Group #13929A** **Employee share is $140.49**	Anthem Plan **3**/Prescription **A** (Health $1121.00 Dental $125.19 Vision $19.80 per month) **Group # 13929C** **Employee share is $34.89**	Anthem Plan **4**/Prescription **A** (Health $1087.00 Dental $125.19 Vision $19.80 per month) **Group #13929D** **Employee share is $.00**
MAJOR MEDICAL	Deductible: $0 Coinsurance: 100%	Deductible:$100 ind/$300 family Coinsurance:100%**Out of pocket max: deductible	Deductible:$100 ind/$300 family Coinsurance:90/10, Out of pocket max $300/person + deductible
Lifetime Max	No Lifetime Max	No Lifetime Max	No Lifetime Max
Calendar Year Max per Person	$5,000,000	$5,000,000	$5,000,000
Doctor Visits	$10 co pay	$20 co pay (co pay not applied to deductible)	$20 co pay(co pay not applied to deductible or out of pocket max)
Prescription co pay/Retail Prescription co pay/Mail Order	$5 Generic $22 Brand $10 Generic;$44 Brand	$5 Generic $22 Brand $10 Generic;$44 Brand	$5 Generic $22 Brand $10 Generic;$44 Brand
Immunizations	Paid @ 100% **	Paid @ 100% **	Paid @ 100% **
Preventative Care for children	**Paid @100%****covered as long as eligible	**Paid @100%****covered as long as eligible	**Paid @100%****covered as long as eligible
Preventative Care for Adults	Paid @ 100% **	Paid @ 100% **	Paid @ 100% **
TELEMEDICINE (new) **www.mdlive.com or 1-888-632-2738**	$5 co pay for **NON** emergency medical conditions	$5 co pay for **NON** emergency medical conditions	$5 co pay for **NON** emergency medical conditions
Outpatient x-ray/lab	Paid at 100% **	Major Medical *	Major Medical *
Radiation, Chemo	Paid at 100% **	Major Medical *	Major Medical *
Durable Medical Equipment	Paid at 100% **	Major Medical *	Major Medical *
Ambulance-Ground/Air	100% of covered expenses	Major Medical *	Major Medical *
Physical Therapy	**Paid @ 100%**** Par Rate to Preferred providers (co pay if applicable) Non-Par providers limited to a combined max of 13 visits per calendar year	Major Medical * (co pay if applicable) Non-Par Providers limited to a combined max of 13 visits per calendar year	Major Medical * (co pay if applicable) Non-Par Providers limited to a combined max of 13 visits per calendar year
Chiropractic	**Paid @ 100%**** Par Rate to Preferred providers (co pay if applicable) Non-Par providers limited to a combined max 13 visits per calendar year	Major Medical * (co pay if applicable) Non-Par providers limited to a combined max 13 visits per calendar year	Major Medical * (co pay if applicable)Non-Par providers limited to a combined max of 13 visits per calendar year
Acupuncture	**Paid @ 100%**** Par Rate to Preferred providers (co pay if applicable) Max of 12 visitsper calendar year	Major Medical * (co pay if applicable) Max of 12 visits per calendar year	Major Medical * (co pay if applicable) Max of 12 visits per calendar year
Hospital-In Patient	Paid @ 100%** Unlimited days; semi-private room	Major Medical * Unlimited days; semi-private room	Major Medical * Unlimited days; semi-private room

Pg 2 continued	Anthem Plan **1**/Prescription **A**	Anthem Plan **3**/Prescription **A**	Anthem Plan **4**/Prescription **A**
HOSPITAL EMERGENCY ROOM	**$75.00 CO PAY** (co pay waived if admitted as inpatient)	**$75.00 CO PAY Major Medical*** (co pay not applied to deductible waived if admitted as in-patient	**$75.00 CO PAY Major Medical*** (co pay not applied to deductible)waived if admitted
Home Health Care	Paid @ 100%** Limited to 100 visits/calendar yr	Major Medical * Limited to 100 visits/calendar yr	Major Medical * Limited to 100 visits per calendar yr
Hospice	100 %** of covered expense	100 %** of covered expense	100 %** of covered expense

Plan Name is	Anthem Plan **7**/Prescription **B** (Health $990.00 Dental $125.19 Vision $19.80 per month)	**HDHP-1(High Ded Health Plan)** (Health $815.00 Dental $125.19 Vision $19.80 per month)	**CVT Wellness** (Health $1006.00 Dental $125.19 Vision $19.80 per month)
	Group # 13929G	**Group #13931N**	**Group #1841NA**
	Employee share is $00.00	**Employee share is $00.00**	**Employee share is $.00**
MAJOR MEDICAL	Deductible: $250 Ind/$750 Fam Coinsurance:80/20 Out of pocket max; $1000 per person + Ded	$1250 Ind/$3000** Family (no individual limits applies) 80/20 coinsurance Out of pocket max: $3000+ded Ind;Fam $7100**+ded **Fam=Emp w/1 or more covered Dep	Deductible:$500 Ind/$1000 Fam Coinsurance: 90/10 Out of pocket max: $500/person plus Ded
Lifetime Max	NO LIFETIME MAX	NO LIFETIME MAX	NO LIFETIME MAX
Calendar Year Max/person	$5,000,000	$5,000,000	$5,000,000
Doctor Visits	$30 co pay (co pay not applied to deductible or out of pocket max)	Major Medical*	$20 Primary Care MD:$40 Specialist (co pays not applied to Ded or Out of pocket max)
TELEMEDICINE (new) **www.mdlive.com or 1-888-632-2738**	$5 co pay for **NON** emergency medical conditions	Major Medical for **NON** emergency medical conditions	$5 co pay for **NON** emergency medical conditions
Prescription co pay/Retail Prescription co pay/Mail Order	$7/$15/$30 $15/$35/$70	Major Medical* Major Medical*	$7/$25/$40 =30day supply $15/$60/$90=90 day supply
Immunizations	Paid @ 100% **	Paid at 100% **	Paid at 100 % **
Preventative Care for children	**Paid @ 100%**** covered as long as eligible	**Paid @ 100%**** covered as long as eligible	Paid at 100 % **-covered as long as eligible
Preventative Care for Adults	Paid @ 100% **	Paid @ 100%**	Paid at 100% **
Outpatient x-ray/lab	**Major Medical***	Major Medical*	Major Medical *
Radiation, Chemo	**Major Medical***	Major Medical*	Major Medical *
Durable Medical Equipment	**Major Medical***	Major Medical*	Major Medical *
Ambulance-Ground/Air	**Major Medical***	Major Medical*	Major Medical *
Physical Therapy	**Major Medical*** (co pay if applicable) Non Par Providers limited to a combined max of 13 visits per calendar year	Major Medical * Non-par providers limited to a combined max of 13 visits per calendar year	Major Medical * (co pay if applicable) Non Par Providers limited to a combined max of 13 visits per calendar year

Pg 3 continued	Anthem Plan **7**/Prescription **B**	**HDHP-1(High Ded Health Plan)**	**CVT Wellness**
Chiropractic	Major Medical * (co pay if applicable) Non-par providers limited to a combined max 13 visits per calendar year	Major Medical * Non-par providers limited to a combined max of 13 visits per calendar year	Major Medical * (co pay if applicable) Non-par providers limited to a combined max 13 visits per calendar year
Acupuncture	Major Medical * (co pay if applicable)Max of 12 visits per calendaryear	Major Medical * max of 12 visits per calendar year	Major Medical * (co pay if applicable)Max of 12 visits per calendaryear
Hospital-In Patient	**Major Medical *** Unlimited days; semi-private room	Major Medical * Unlimited days, semi-private room	Major Medical * Unlimited days, semi-private room
HOSPITAL EMERGENCY ROOM	**$75.00 CO PAY** Major Medical * (co pay not applied to deductible or out of pocket max) waived if admitted as in-patient	Major Medical *	**$75.00 CO PAY Major Medical*** (Co pay not applied to ded or out of pocket max **Waived if admitted**)
Home Health Care	**Major Medical *** Limited to 100 visits/calendar yr	**Major Medical *** Limited to 100 visits/calendar yr	Major Medical * Limited to 100 visits per calendar year
Hospice	100 % of covered expense	**Major Medical ***	100 % of Covered Expense

Plan Name is	**CVT Bronze Plan** (Health $555.00 Dental $125.19 Vision $19.80 per month)	**Kaiser 1 HMO** (Health $1286.00 Dental $125.19 Vision $19.80 per month)	**Kaiser 3 HMO** (Health $1173.00 Dental $125.19 Vision $19.80 per month)
	Group # 1853YA **Employee share is $00.00**	**Group # 0815-0000** **Employee share is $232.89**	**Group #0815-0013** **Employee share is $97.29**
MAJOR MEDICAL	Deductible:$5,000.00 Ind/10,000.00 Fam Coinsurance: 70/30 Out of pocket max: $6400/person $12800 per Family	Deductible:0 Out of pocket max: $1500/person $3000 per Family	Deductible:0 Out of pocket max: $1500/person $3000 per Family
Lifetime Max	NO LIFETIME MAX	NO LIFETIME MAX	NO LIFETIME MAX
Calendar Year Max/person	$5,000,000		
Doctor Visits	$60 Co pay;First 3 visits in Full after co pay Remaining visits-Major Med	$10 co pay; $5 allergy injections (50% infertility)	$20 co pay ;$5 allergy injections (50% infertility)
TELEMEDICINE (new) **www.mdlive.com or 1-888-632-2738**	$5 co pay for **NON** emergency medical conditions	N/A	N/A
Prescription co pay/Retail Prescription co pay/Mail Order	Subject to Med Ded, then $25 Co pay Generic;$50 Co pay Brand	$5/$10 =30day supply; $10/$20=31-60 supply $15/$30=61-100 day supply $5/$10=30 day $10 /$20= 31-100 day supply	$10/$20 =30day supply; $20/$40=31-60 supply $30/$60=61-100 day supply $10/$20=30day; $20/40= 31-100 day supply
Immunizations	100 % in Network	Covered/no charge	Covered/no charge
Preventative Care for children	100 % in Network	Covered/no charge	Covered/no charge

Pg 4 continued	**CVT Bronze Plan**	**Kaiser 1 HMO**	**Kaiser 3 HMO**
Preventative Care for Adults	100 % in Network	Covered/no charge	Covered/no charge
Outpatient x-ray/lab	Major Medical *	Covered/no charge	Covered/no charge
Radiation, Chemo	Major Medical *	Covered/no charge;Chemo $10 co pay	Covered/no charge;Chemo $20 co pay
Durable Medical Equipment	Major Medical *	Covered/no charge(w/DME formulary)	Covered/no charge(w/DME formulary)
Ambulance-Ground/Air	Major Medical *	Covered/no charge(if med necessary)	Covered/no charge(if med necessary)
Physical Therapy	Major Medical * Non-Par Providers limited to max 13 visits per calendar year	Covered w/ $10 co pay	Covered w/ $20 co pay
Chiropractic	Major Medical * Non-Par Providers limited to max 13 visits per calendar year	NOT COVERED	NOT COVERED
Acupuncture	Major Medical * Max 12 visits per calendar year	Covered w/ $10 co pay Referral by Plan Physician	Covered w/ $20 co pay Referral by Plan Physician
Hospital-(In Patient,Outpatient,Surgical)	Subject to Ded/Coinsurance	Covered/ no charge	Covered/ no charge
HOSPITAL EMERGENCY ROOM	Subject to Ded, then **$250** Co-pay **URGENT CARE-Subject to ded,then $120 co pay**	**$35.00 CO PAY (waived if admitted)**	**$50.00 CO PAY (waived if admitted)**
Home Health Care	Major Medical * 100 visits per calendar year	Covered/no charge (limits)	Covered/No charge (limits)
Hospice	Major Medical *	Covered/no charge	Covered/No charge
Vision	N/A	Covered/no charge;No frames, lenses, contact allowance	Covered/no charge;No frames, lenses, contact allowance

Plan Name is	**Kaiser 6 HMO** (Health $1023.00 Dental $125.19 Vision $19.80 per month) **Group # 0815-0104** **Employee share is $.00**	**Kaiser 8 HMO** (Health $939.00 Dental $125.19 Vision $19.80 per month) **Group # 0815-0300** **Employee share is $.00**	**Kaiser Wellness** (Health $1051.00 Dental $125.19 Vision $19.80 per month) **Group # 0815-0365** **Employee share is $.00**
MAJOR MEDICAL	Deductible:0 Out of pocket max: $1500/person $3000 Family	Deductible:$1000 Ind/$2000 Fam Out of pocket max: $3000/person $6000 Per Family	Deductible:$.00 Ind/.00 Fam Out of pocket max: $1500/person $3000 Two or more members
Lifetime Max	NO LIFETIME MAX	NO LIFETIME MAX	NO LIFETIME MAX
Calendar Year Max/person			
Doctor Visits	Covered $25 Co pay (50% infertility, $5 allergy injections)	Covered $20 Co pay(no ded) (50% infertility, no charge allergy injections)	$20 Primary Care Co pay/$40 Specialist Co pay (50% infertility,$5 allergy injections)
Prescription co pay/Retail Prescription co pay/Mail Order	$10/$20 =30day supply; $20/$40=31-60 supply $30/$60=61-100 day supply $10/$20=30day; $20/40= 31-100 day supply	$10/$30 =30day supply; $20/$60=31-60 supply $30/$90=61-100 day supply $10/$30=30day; $20/60= 31-100 day supply	$10/$25 =30 day supply; $20/$50 =100 day supply;
Immunizations	Covered/no charge	Covered/no charge	Covered/no charge

Pg 5 continued	**Kaiser 6 HMO**	**Kaiser 8 HMO**	**Kaiser Wellness**
Preventative Care for children	Covered/no charge	Covered/no charge	Covered/no charge
Preventative Care for Adults	Covered/no charge	Covered/no charge	Covered/no charge
Outpatient x-ray/lab	Covered/no charge	Covered/No Ded, $10 Co pay	Covered, $10 Co pay
Radiation, Chemo	Covered/no charge;Chemo $25 co pay	Covered/20% after Ded; Chemo no charge	Covered/no charge;Chemo $40 co pay
Durable Medical Equipment	Covered/no charge(w/DME formulary)	Covered 20% coinsurance No Ded(w/DME)	Covered/no charge(w/DME formulary)
Ambulance-Ground/Air	Covered, $50/trip(if med necessary)	Covered, $150/trip(if med necessary)No Ded	Covered, $100 co pay(if med necessary)
Physical Therapy	Covered w/ $25 co pay	Covered w/ $20 co pay, No Ded	Covered, $20 co pay
Chiropractic	NOT COVERED	NOT COVERED	NOT COVERED
Acupuncture	Covered, $25 co pay Referral by Plan Physician	Covered, $20 co pay No Ded Referral by Plan Physician	Covered, $40 co pay Referral by Plan Physician
Hospital-In Patient	Covered,$250 Co pay	Covered,20% coinsurance after deductible	Covered,$500 Co pay per admission Unlimited days,semi private room
HOSPITAL EMERGENCY ROOM	**$50.00 CO PAY** **(waived if admitted)**	Covered,20% coinsurance after deductible	Covered,$35 Co pay **(waived if admitted)**
Home Health Care	Covered/No charge (limits)	Covered/No charge (limits)	Covered/No charge (Up to 100 visits per calendar year)
Hospice	Covered/No charge	Covered/No charge	Covered/No charge
Vision	Covered/no charge;$175 frame,lenses,contact allowance	Covered/no charge;NO frame,lenses,contact allowance	Covered/no charge;NO frame,lenses,contact allowance

HEALTH BENEFIT CALCULATOR
www.cvtrust.org/calculator

INSURANCE INFORMATION

Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007 www.bluecrossca.com 1-800-234-4333 Pre Admission 1-888-274-7767	Kaiser Member Service PO Box 12923 Oakland, CA 94604-2923 www.kaiserpermante.org 1-800-464-4000	Vision Service Plan One Market ST Plaza Ste 2625 Steuart St Tower, SF CA 94105 www.vsp.com 1-800-877-7195	***This summary is subject to change based on further healthcare reform guidelines and is for comparison purposes only.*** (PPACA Law)
Caremark/CVS PO Box 961066 Fort Worth TX 76161-0066 www.caremark.com 1-888-354-6390	Delta Dental Insurance PO Box 7736 San Francisco CA 94120 www.deltadentalca.org 1-866-499-3001	California's Valued Trust PO Box 26300 Fresno CA 93729-69300 www.cvtrust.org 7-800-288-9870	

Using Non-PPO & Other Health Care Providers

Members are responsible for any difference between the covered expense and the actual charges as well as any deductible or co pay

*** Major Medical**- Deductible and coinsurance apply

**** Explanation of covered expense:** Plan payments are based on a covered expense, which is the lesser of the charges billed by the provider or the following: PPO Providers- PPO negotiated rates, members are not responsible for the difference between the provider's usual charge and the negotiated amount

Non PPO Providers-For non-emergency services, the schedule amount. For emergency services, same as other health care providers.

Other Health Care Providers-(includes those not represented in the PPO provider network) The customary & reasonable charge for professional services or the reasonable charge for institutional services