

CVT HMO Health Plans with Kaiser Permanente
Nevada Joint Union High SD - CERTIFICATED, CLASSIFIED, MANAGEMENT

October 1, 2019 - September 30, 2020

| BENEFIT | Kaiser 3 W / CHIRO | Kaiser 3 | Kaiser 7 | Kaiser Wellness | Kaiser HSA |
|---|--|---|---|---|---|
| Calendar Year Deductible | \$0 | \$0 | \$0 | \$0 | Self-Only Coverage: \$2,000 (A family of one member) Family Coverage: \$2,700 (Each member in a family of two or more members) Family Coverage: \$4,000 (Entire family of two or more members) |
| Coinsurance | Paid at 100%* | Paid at 100%* | Paid at 100%* | Paid at 100%* | Not applicable |
| Calendar Year Out of Pocket Maximum (includes medical/pharmacy deductible, coinsurance, and copays) ⁽²⁾ | Individual: \$1,500 Family: \$3,000 | Individual: \$1,500 Family: \$3,000 | Individual: \$1,500 Family: \$3,000 | Individual: \$1,500 Family: \$3,000 | Self-Only Coverage: \$3,000 (A family of one member) Family Coverage: \$3,000 (Each member in a family of two or more members) Family Coverage: \$6,000 (Entire family of two or more members) |
| Doctor Visits | Primary Care Physician - \$20 Copay Specialty Physician - \$20 Copay | Primary Care Physician - \$20 Copay Specialty Physician - \$20 Copay | Primary Care Physician - \$35 Copay Specialty Physician - \$35 Copay | Primary Care Physician - \$20 Copay Specialty Physician - \$40 Copay | Primary Care Physician - \$30 copay after deductible is met Specialty Physician - \$30 copay after deductible is met |
| Preventive Care / Immunizations | Paid at 100%* | Paid at 100%* | Paid at 100%* | Paid at 100%* | Paid at 100%* |
| Outpatient Laboratory | Paid at 100%* | Paid at 100%* | Paid at 100%* | \$10 Copay | \$10 copay after deductible is met |
| Outpatient Radiology | Radiation Therapy:Paid at 100%* Chemotherapy:\$20 Copay | Radiation Therapy:Paid at 100%* Chemotherapy:\$20 Copay | Radiation Therapy:Paid at 100%* Chemotherapy:\$35 Copay | Radiation Therapy:Paid at 100%* Chemotherapy:\$40 Copay | Paid at 100%*, after deductible is met |
| Durable Medical Equipment | Paid at 100%* | Paid at 100%* | Paid at 80%* | Paid at 100%* | Paid at 80%* after deductible is met |
| Ambulance - Ground / Air | Paid at 100%* If Medically Necessary | Paid at 100%* If Medically Necessary | \$100 Per Trip If Medically Necessary | \$100 Copay If Medically Necessary | \$100 copay after deductible is met |
| Physical Therapy | \$20 Copay | \$20 Copay | \$35 Copay | \$20 Copay | \$30 copay after deductible is met |
| Chiropractic | Benefit through PhysMetrics; \$10 office visit copay; \$15 daily max for out of network; Up to 40 visits per year - After 12 th visit must be pre-certified | Not Covered | Not Covered | Not Covered | Not Covered |
| Acupuncture | \$20 Copay Referral by Plan Physician | \$20 Copay Referral by Plan Physician | \$35 Copay Referral by Plan Physician | \$40 Copay Referral by Plan Physician | \$30 copay after deductible is met Referral by plan physician |
| Outpatient Surgery | \$20 Copay | \$20 Copay | \$250 Copay | \$500 Per Procedure | \$150 copay per admission after deductible is met |
| Hospital Inpatient | Paid at 100%* | Paid at 100%* | \$250 Copay | \$500 Copay Per Admission Unlimited days, semi-private room | \$250 copay per admission after deductible is met |

| BENEFIT | Kaiser 3 W / CHIRO | | Kaiser 3 | | Kaiser 7 | | Kaiser Wellness | | Kaiser HSA | |
|--|--|--|--|---|--|---|--|---|--|---|
| Hospital Emergency Room | \$100 Copay Copay waived if admitted as in-patient | | \$100 Copay Copay waived if admitted as in-patient | | \$100 Copay Copay waived if admitted as in-patient | | \$100 Copay (Copay waived if admitted as in-patient) | | \$100 copay per visit after deductible is met | |
| Urgent Care | \$20 Copay | | \$20 Copay | | \$35 Copay | | \$20 Copay | | \$30 copay after deductible is met | |
| Home Health Care | Paid at 100%* (Limits) | | Paid at 100%* (Limits) | | Paid at 100%* (Limits) | | Paid at 100%* (Limits) | | Paid at 100%* (Limits) | |
| Telehealth | For after-hours advice, call 1-888-576-6225 | | For after-hours advice, call 1-888-576-6225 | | For after-hours advice, call 1-888-576-6225 | | For after-hours advice, call 1-888-576-6225 | | For after-hours advice, call 1-888-576-6225 | |
| Medical Decision Support | N/A | | N/A | | N/A | | N/A | | N/A | |
| Employee Assistance Program (EAP) through Beacon Health Options | Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽³⁾ | | Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽³⁾ | | Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽³⁾ | | Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽³⁾ | | Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽³⁾ | |
| Prescription Drugs | Retail \$10 Generic \$20 Brand (Up to 30 Day Supply) \$20 Generic \$40 Brand (31-60 Day Supply) \$30 Generic \$60 Brand (61-100 Day Supply) | Mail Order \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-60 Day Supply) \$40 Brand (31-100 Day Supply) | Retail \$10 Generic \$20 Brand (Up to 30 Day Supply) \$20 Generic \$40 Brand (31-60 Day Supply) \$30 Generic \$60 Brand (61-100 Day Supply) | Mail Order \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-100 Day Supply) | Retail \$10 Generic \$30 Brand (Up to 30 Day Supply) \$20 Generic \$60 Brand (31-60 Day Supply) \$30 Generic \$90 Brand (61-100 Day Supply) | Mail Order \$10 Generic \$30 Brand (30 Day Supply) \$20 Generic \$60 Brand (31-100 Day Supply) | Retail \$10 Generic \$25 Brand (30-day supply) \$20 Generic \$50 Brand (31-60 day supply) \$20 Generic \$50 Brand (31 - 100 day supply) | Mail Order \$10 Generic \$25 Brand (up to 30 day supply) | Retail \$10 Generic \$30 Brand (30 day supply) \$20 Generic \$60 Brand (31-60 day supply) \$30 Generic \$90 Brand (61-100 day supply) After Deductible is Met | Mail Order \$10 Generic \$30 Brand (Up to 30 day supply) \$20 Generic \$60 Brand (31 - 100 day supply) After Deductible is Met |

Kaiser Permanente Plans:

*** For Covered Expenses Only**

(2) The pharmacy copayments will not apply to out of pocket maximums for retirees enrolled in Medicare

NOTES: Copays for Infertility: Plans 1 - \$10 Copay; Plan 2 - \$15 Copay; Plan 3 - 50% Copay; Plan 4 - \$30 Copay; Plan 5 - \$35 Copay; Plans 6-8 & Wellness - 50% Copay.

Copays for Allergy Injections: Plans 1-5 - No Charge; Plans 6-7 & Wellness - \$5 Per Visit; Plan 8 - No Charge.

Plan 6 - \$175 allowance for lenses, frames & contacts every 24 months

(3) EAP - Up to 6 counseling sessions per covered member, per benefit year (max 2 episodes/courses of treatment).

This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits at www.cvtrust.org/plan-documents.