

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

October 1, 2021 - September 30, 2022

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 combined with Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Acupuncture	Benefit through PhysMetrics; \$10 office visit copay; \$15 daily max for out of network; Up to 40 visits per year combined with Chiropractic	\$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 (31-100 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) \$30 Generic \$75 Brand (61-100 day supply)	Mail Order \$10 Generic \$25 Brand (up to 30 day supply) \$20 Generic \$50 Brand (31 - 100 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.