CVT HMO Health Plans with Kaiser Permanente

Wright Elementary SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2023 - September 30, 2024

BENEFIT	HMO 2	HMO 3	HMO Wellness	HMO Wellness w/Chiro	HMO HSA
Calendar Year Deductible	$0	$0	$0	$0	Self-Only Coverage: $2,000 (A family of one member) Family Coverage: $2,800 (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** - $15 Copay **Specialty Physician** - $15 Copay	**Primary Care Physician** - $20 Copay **Specialty Physician** - $20 Copay	**Primary Care Physician** - $20 Copay **Specialty Physician** - $40 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	Most tests paid at 100%*	Most tests paid at 100%*	$10 Copay	$10 Copay	$10 copay after deductible is met
Outpatient Radiology	Most services paid at 100%*	Most services paid at 100%*	Most services paid at 100%*	Most services paid at 100%*	**Preventive X-rays, screenings, lab tests:** Paid at 100%, No deductible **MRI, most CT, and PET scans:** $50 per procedure after deductible is met
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 100%*	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 Copay If Medically Necessary	$100 Copay If Medically Necessary	$100 copay after deductible is met
Physical Therapy	$15 Copay	$20 Copay	$20 Copay	$20 Copay	$30 copay after deductible is met
Chiropractic	Not Covered	Not Covered	Not Covered	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
Acupuncture	$15 Copay Referral by Plan Physician	$20 Copay Referral by Plan Physician	$40 Copay Referral by Plan Physician	Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Chiropractic	$30 copay after deductible is met Referral by plan physician

BENEFIT	HMO 2		HMO 3		HMO Wellness		HMO Wellness w/Chiro		HMO HSA	
Outpatient Surgery	$15 Copay		$20 Copay		$500 Per Procedure		$500 Per Procedure		$150 copay per admission after deductible is met	
Hospital Inpatient	Paid at 100%*		Paid at 100%*		$500 Copay Per Admission Unlimited days, semi-private room		$500 Copay Per Admission Unlimited days, semi-private room		$250 copay per admission after deductible is met	
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	$15 Copay		$20 Copay		$20 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 Carelon	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** $5 Generic $10 Brand (Up to 30 Day Supply) $10 Generic $20 Brand (31-60 Day Supply) $15 Generic $30 Brand (61-100 Day Supply)	**Mail Order** $5 Generic $10 Brand (30 Day Supply) $10 Generic $20 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 $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 $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.