

**CALIFORNIA'S VALUED TRUST**  
**KAISER PERMANENTE HEALTH / RX PLANS – 1 Through 8**  
**October 1, 2020 – September 30, 2021**

BENEFIT	KAISER 1	KAISER 2	KAISER 3	KAISER 4	KAISER 5	KAISER 6 w/ Optical Benefit	KAISER 7	KAISER 8 Deductible Plan
<b>Calendar Year Deductible</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	Individual: \$1,000 Family: \$2,000
<b>Coinsurance</b>	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
<b>Calendar Year Out of Pocket Maximum</b> (includes medical/pharmacy deductible, coinsurance, and copays) †	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$1,500 Family: \$3,000	Individual: \$3,000 Family: \$6,000
<b>Doctor Visits</b>	Primary Care – \$10 Copay Specialty – \$10 Copay	Primary Care – \$15 Copay Specialty – \$15 Copay	Primary Care – \$20 Copay Specialty – \$20 Copay	Primary Care – \$30 Copay Specialty – \$30 Copay	Primary Care – \$35 Copay Specialty – \$35 Copay	Primary Care – \$25 Copay Specialty – \$25 Copay	Primary Care – \$35 Copay Specialty – \$35 Copay	Primary Care – \$20 Copay Specialty – \$20 Copay No Deductible
<b>Preventive Care / Immunizations</b>	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%* No Deductible
<b>Outpatient Laboratory</b>	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	\$10 Copay, No Deductible
<b>Outpatient Radiology</b>	Radiation Therapy: Paid at 100%* Chemotherapy: \$10 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$15 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$20 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$30 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$35 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$25 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: \$35 Copay	Radiation Therapy: Paid at 100% after Deductible is met Chemotherapy: Paid at 100%, No Deductible
<b>Durable Medical Equipment</b>	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 80%	Paid at 80%, No Deductible
<b>Ambulance – Ground/Air</b>	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	\$50 Per Trip If Medically Necessary	\$100 Per Trip If Medically Necessary	\$150 Per Trip, If Medically Necessary No Deductible
<b>Physical Therapy</b>	\$10 Copay	\$15 Copay	\$20 Copay	\$30 Copay	\$35 Copay	\$25 Copay	\$35 Copay	\$20 Copay No Deductible
<b>Chiropractic</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Acupuncture</b>	\$10 Copay Referral by Plan Physician	\$15 Copay Referral by Plan Physician	\$20 Copay Referral by Plan Physician	\$30 Copay Referral by Plan Physician	\$35 Copay Referral by Plan Physician	\$25 Copay Referral by Plan Physician	\$35 Copay Referral by Plan Physician	\$20 Copay, No Deductible Referral by Plan Physician

<b>Page 2</b>	<b>KAISER 1</b>	<b>KAISER 2</b>	<b>KAISER 3</b>	<b>KAISER 4</b>	<b>KAISER 5</b>	<b>KAISER 6 w/ Optical Benefit</b>	<b>KAISER 7</b>	<b>KAISER 8 Deductible Plan</b>
<b>Outpatient Surgery</b>	\$10 Copay	\$15 Copay	\$20 Copay	\$30 Copay	\$35 Copay	\$25 Copay	\$250 Copay	Paid at 80% after Deductible is met
<b>Hospital Inpatient</b>	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	\$250 Copay	\$250 Copay	Paid at 80% after Deductible is met
<b>Hospital Emergency Room</b>	\$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 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	Paid at 80% after Deductible is met
<b>Urgent Care</b>	\$10 Copay	\$15 Copay	\$20 Copay	\$30 Copay	\$35 Copay	\$25 Copay	\$35 Copay	\$20 Copay
<b>Home Health Care</b>	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* No Deductible (Limits)
<b>Telehealth</b>	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	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
<b>Employee Assistance Program (EAP) through Beacon Health Options~</b>	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit	Paid at 100%* - Visit <a href="http://www.achievesolution.net/cvt">www.achievesolution.net/cvt</a> or call 1-877-397-1032 to access benefit
<b>Prescription Drugs</b>	<u>Retail</u> \$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)  <u>Mail Order</u> \$5 Generic \$10 Brand (30 Day Supply) \$10 Generic \$20 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$5 Generic \$10 Brand (30 Day Supply) \$10 Generic \$20 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$20 Brand (30 Day Supply) \$20 Generic \$40 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$30 Brand (30 Day Supply) \$20 Generic \$60 Brand (31-100 Day Supply)	<u>Retail</u> \$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)  <u>Mail Order</u> \$10 Generic \$30 Brand (30 Day Supply) \$20 Generic \$60 Brand (31-100 Day Supply)

**\* For Covered Expenses Only**

† The pharmacy copayments will not apply to out of pocket maximums for retirees enrolled in a Medicare Senior Advantage Plan.

**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 – 50% Copay.**

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

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

~ 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 Evidence of Coverage for complete benefits at [www.cvtrust.org/plan-documents](http://www.cvtrust.org/plan-documents)**