

CVT PPO Health Plans

Lucerne Valley Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2016 - September 30, 2017

BENEFIT	PPO 4C	PPO 7C	PPO 8C	PPO 9C	PPO Wellness
Calendar Year Deductible	Individual: \$100 Family: \$300	Individual: \$250 Family: \$750	Individual: \$500 Family: \$1,500	Individual: \$1,000 Family: \$3,000	Individual: \$500 Family: \$1,000
Coinsurance	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical and pharmacy copays)	Individual: \$1,250 ⁽²⁾ Family: \$3,750 ⁽²⁾	Individual: \$2,000 ⁽²⁾ Family: \$6,000 ⁽²⁾	Individual: \$3,250 ⁽²⁾ Family: \$9,750 ⁽²⁾	Individual: \$5,000 ⁽²⁾ Family: \$10,000 ⁽²⁾	Individual: \$1,750 ⁽²⁾ Family: \$5,250 ⁽²⁾
Doctor Visits (Primary Care Physician)	\$20 Copay	\$30 Copay	\$30 Copay	\$35 Copay	\$20 Copay
Doctor Visits (Specialty Physician)	\$20 Copay	\$30 Copay	\$30 Copay	\$35 Copay	\$40 Copay
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Diagnostic Test / Imaging	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Radiation Therapy, Chemotherapy	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Ambulance - Ground / Air	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Physical Therapy	Paid at 90%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 90%* ⁽¹⁾ after deductible is met (Copay, if applicable.)
Chiropractic	Paid at 90%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 80%* ⁽¹⁾ after deductible is met (Copay, if applicable.)	Paid at 90%* ⁽¹⁾ after deductible is met (Copay, if applicable.)
Acupuncture	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 80%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 80%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 80%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year
Outpatient Surgery	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 90%* after deductible is met
Hospital Inpatient	Paid at 90%* after deductible is met; Unlimited days, Semi-private room (RBB price cap)⁽³⁾	Paid at 80%* after deductible is met; Unlimited days, Semi-private room (RBB price cap)⁽³⁾	Paid at 80%* after deductible is met; Unlimited days, Semi-private room (RBB price cap)⁽³⁾	Paid at 80%* after deductible is met; Unlimited days, Semi-private room (RBB price cap)⁽³⁾	Paid at 90%* after deductible is met; Unlimited days, Semi-private room (RBB price cap)⁽³⁾

BENEFIT	PPO 4C		PPO 7C		PPO 8C		PPO 9C		PPO Wellness	
Hospital Emergency Room	\$100 Copay (Copay waived if admitted as inpatient) Paid at 90%* after deductible is met		\$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met		\$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met		\$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met		\$100 Copay (Copay waived if admitted as inpatient) Paid at 90%* after deductible is met	
Urgent Care	\$20 Copay		\$30 Copay		\$30 Copay		\$35 Copay		\$20 Copay	
Home Health Care	Paid at 90%* after deductible is met; Limited to 100 visits per calendar year		Paid at 80%* after deductible is met; Limited to 100 visits per calendar year		Paid at 80%* after deductible is met Limited to 100 visits per calendar year		Paid at 80%* after deductible is met; Limited to 100 visits per calendar year		Paid at 90%* after deductible is met; Limited to 100 visits per calendar year	
Telemedicine	MDLIVE - \$5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		MDLIVE - \$5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		MDLIVE - \$5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		MDLIVE - \$5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		MDLIVE - \$5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	
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 ⁽⁴⁾		Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾		Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾		Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾		Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾	
Prescription Drugs Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for PPO prescription plans A, B, C (includes Wellness) and D	Retail \$7 Generic \$25 Pref \$40 Non-Pref (30-Day Supply)	Mail Order \$15 Generic \$60 Pref \$90 Non-Pref (90-Day Supply)	Retail \$7 Generic \$25 Pref \$40 Non-Pref (30-Day Supply)	Mail Order \$15 Generic \$60 Pref \$90 Non-Pref (90-Day Supply)	Retail \$7 Generic \$25 Pref \$40 Non-Pref (30-Day Supply)	Mail Order \$15 Generic \$60 Pref \$90 Non-Pref (90-Day Supply)	Retail \$7 Generic \$25 Pref \$40 Non-Pref (30-Day Supply)	Mail Order \$15 Generic \$60 Pref \$90 Non-Pref (90-Day Supply)	Retail \$7 Generic \$25 Pref \$40 Non-Pref (30-Day Supply)	Mail Order \$15 Generic \$60 Pref \$90 Non-Pref (90-Day Supply)

PPO Plans:

* For Covered Expenses Only: When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible & percentage copay. All percentages are based on payments to preferred hospitals, physicians and other network providers.

(1) Non-Par Providers limited to a combined maximum of 13 visits per year.

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

(3) Reference Based Benefit (RBB) is a regional price cap for inpatient Hip Replacement, Hysterectomy, Knee Replacement and Laminectomy for Anthem Blue Cross PPO Plans.

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

CVT Blue Shield HMO Plans

Lucerne Valley Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2016 - September 30, 2017

BENEFIT	HMO PLAN 1	HMO PLAN 2	HMO PLAN 3
Calendar Year Deductible	\$0	\$0	\$0
Coinsurance	Paid at 100%*	Paid at 100%*	Paid at 100%*
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical and pharmacy copays)	Individual: \$1,000 Family: \$2,000	Individual: \$1,500 Family: \$3,000	Individual: \$3,500 Family: \$6,000
Doctor Visits (Primary Care Physician)	\$10 Copay	\$15 Copay	\$25 Copay
Doctor Visits (Specialty Physician)	\$30 Copay Access+ Specialist option ⁽⁶⁾	\$30 Copay Access+ Specialist option ⁽⁶⁾	\$40 Copay Access+ Specialist option ⁽⁶⁾
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Diagnostic Test / Imaging	Paid at 100%*	Paid at 100%*	Paid at 100%*
Radiation Therapy, Chemotherapy	Doctor Visit - \$10 Copay Outpatient - Paid in full	Doctor Visit - \$15 Copay Outpatient - Paid in full	Doctor Visit - \$25 Copay Outpatient - Paid in full
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 100%*
Ambulance - Ground / Air	\$100 Copay	\$100 Copay	\$100 Copay
Physical Therapy	\$10 Per Visit	\$15 Per Visit	\$25 Per Visit
Chiropractic	\$10 copay limited up to 30 visits per calendar year (Prior authorization not required) ⁽⁵⁾	\$10 copay limited up to 30 visits per calendar year (Prior authorization not required) ⁽⁵⁾	\$10 copay limited up to 30 visits per calendar year (Prior authorization not required) ⁽⁵⁾
Acupuncture	Not Covered	Not Covered	Not Covered
Outpatient Surgery	Paid at 100%*	\$100 for Ambulatory Surgical Center \$150 for OutPatient Hospital	\$250 for Ambulatory Surgical Center \$500 for OutPatient Hospital
Hospital Inpatient	Physician paid at 100%* Inpatient facility services - Paid at 100%* Skilled Nursing - Paid at 100%* Semi-private room	Physician paid at 100%* Inpatient facility services - \$250 copay per admission Skilled Nursing - \$50 per day copay; Semi private room	Physician paid at 100%* Inpatient facility services - \$750 per day copay for up to 3 days, per admission Skilled Nursing - \$150 per day copay; Semi private room
Hospital Emergency Room	\$100 Copay (Copay waived if admitted as in-patient)	\$100 Copay (Copay waived if admitted as in-patient)	\$150 Copay (Copay waived if admitted as in-patient)
Urgent Care	\$10 Copay	\$15 Copay	\$25 Copay
Home Health Care	\$10 Per Visit (limited to 100 visits per calendar year)	\$15 Per Visit (limited to 100 visits per calendar year)	\$25 Per Visit (limited to 100 visits per calendar year)
Telemedicine	For non-emergency care, call NurseHelp 24/7 at (877) 304-0504	For non-emergency care, call NurseHelp 24/7 at (877) 304-0504	For non-emergency care, call NurseHelp 24/7 at (877) 304-0504
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 ⁽⁴⁾	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾

BENEFIT	HMO PLAN 1	HMO PLAN 2	HMO PLAN 3
<p>Prescription Drugs Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for PPO prescription plans A, B, C (includes Wellness) and D</p>	<p>Retail \$5 Generic \$10 Formulary Brand \$25 Non-Formulary Brand Mail Order \$10 Generic \$20 Formulary Brand \$50 Non-Formulary Brand Specialty Drugs Paid at 80%* (Up to \$100 copayment maximum per prescription) 30-Day Supply</p>	<p>Retail \$10 Generic \$20 Formulary Brand \$35 Non-Formulary Brand Mail Order \$20 Generic \$40 Formulary Brand \$70 Non-Formulary Brand Specialty Drugs Paid at 80%* (Up to \$100 copayment maximum per prescription) 30-Day Supply</p>	<p>Retail \$15 Generic \$30 Formulary Brand \$45 Non-Formulary Brand Mail Order \$30 Generic \$60 Formulary Brand \$90 Non-Formulary Brand Specialty Drugs Paid at 80%* (Up to \$100 copayment maximum per prescription) 30-Day Supply</p>

Blue Shield HMO Plans:

(5) Chiropractic benefits are offered through ASH.

(6) To use the Access+ Specialist option, a member must select a primary care personal physician who is affiliated with a medical group or IPA that is an Access+ provider group that offers the Access+ Specialist feature.

CVT Kaiser Health Plans

Lucerne Valley Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2016 - September 30, 2017

BENEFIT	Kaiser 2	Kaiser 3	Kaiser 5	Kaiser Wellness
Calendar Year Deductible	\$0	\$0	\$0	\$0
Coinsurance	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical and pharmacy copays)	Individual: \$1,500 ⁽²⁾ Family: \$3,000 ⁽²⁾	Individual: \$1,500 ⁽²⁾ Family: \$3,000 ⁽²⁾	Individual: \$1,500 ⁽²⁾ Family: \$3,000 ⁽²⁾	Individual: \$1,500 ⁽²⁾ Family: \$3,000 ⁽²⁾
Doctor Visits (Primary Care Physician)	\$15 Copay	\$20 Copay	\$35 Copay	\$20 Copay
Doctor Visits (Specialty Physician)	\$15 Copay	\$20 Copay	\$35 Copay	\$40 Copay
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Diagnostic Test / Imaging	Paid at 100%*	Paid at 100%*	Paid at 100%*	\$10 Copay
Radiation Therapy, Chemotherapy	Radiation Therapy: Paid at 100%* Chemotherapy: \$15 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
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Ambulance - Ground / Air	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	\$100 Copay If Medically Necessary
Physical Therapy	\$15 Copay	\$20 Copay	\$35 Copay	\$20 Copay
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Acupuncture	\$15 Copay Referral by Plan Physician	\$20 Copay Referral by Plan Physician	\$35 Copay Referral by Plan Physician	\$40 Copay Referral by Plan Physician
Outpatient Surgery	\$15 Copay	\$20 Copay	\$35 Copay	\$500 Per Procedure
Hospital Inpatient	Paid at 100%*	Paid at 100%*	Paid at 100%*	\$500 Copay Per Admission Unlimited days, semi-private room
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)
Urgent Care	\$15 Copay	\$20 Copay	\$35 Copay	\$20 Copay
Home Health Care	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)
Telemedicine	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
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 ⁽⁴⁾	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾	Paid at 100% - Visit www.achievesolutions.net/cvt or call 1-877-397-1032 to access benefit ⁽⁴⁾

BENEFIT	Kaiser 2		Kaiser 3		Kaiser 5		Kaiser Wellness	
Prescription Drugs Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for PPO prescription plans A, B, C (includes Wellness) and D	Retail		Retail		Retail		Retail	Mail Order
	\$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)	\$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)	\$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)	\$10 Generic \$25 Brand (30-day supply) \$20 Generic \$50 Brand (31-60 day supply) \$30 Generic \$75 Brand (61-100 day supply)	\$20 Generic \$25 Brand (up to 30 day supply) \$20 Generic \$50 Brand (31 - 100 day supply)

Kaiser Permanente Plans:

NOTE: 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