CALIFORNIA'S VALUED TRUST
KAISER PERMANENTE HEALTH / RX PLANS
October 1, 2024 – September 30, 2025

BENEFIT	KAISER 1	KAISER 3	KAISER 5	KAISER 8 Deductible Plan
Calendar Year Deductible	$0	$0	$0	Individual: $1,000 Family: $2,000
Coinsurance	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Calendar Year Out of Pocket Maximum (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: $3,000 Family: $6,000
Doctor Visits	Primary Care – $10 Copay Specialty – $10 Copay	Primary Care – $20 Copay Specialty – $20 Copay	Primary Care – $35 Copay Specialty – $35 Copay	Primary Care – $20 Copay Specialty – $20 Copay No Deductible
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%* No Deductible
Outpatient Laboratory	Most tests paid at 100%*	Most tests paid at 100%*	Most tests paid at 100%*	$10 Copay, No Deductible
Outpatient Radiology	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: Paid at 80%* up to max $50 per procedure, No deductible
Durable Medical Equipment	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 80%, No Deductible
Ambulance – Ground/Air	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary	$150 Per Trip, If Medically Necessary No Deductible
Physical Therapy	$10 Copay	$20 Copay	$35 Copay	$20 Copay No Deductible
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay Referral by Plan Physician	$20 Copay Referral by Plan Physician	$35 Copay Referral by Plan Physician	$20 Copay, No Deductible Referral by Plan Physician

Page 2	KAISER 1	KAISER 3	KAISER 5	KAISER 8 Deductible Plan
Outpatient Surgery	$10 Copay	$20 Copay	$35 Copay	Paid at 80% after Deductible is met
Hospital Inpatient	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 80% 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	Paid at 80% after Deductible is met
Urgent Care	$10 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%* No Deductible (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
Employee Assistance Program (EAP) through Carelon~	Paid at 100%* - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	Paid at 100%* - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	Paid at 100%* - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	Paid at 100%* - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit
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 $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)

*** 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