

CVT PPO Health Plans with Anthem Blue Cross and CVS/caremark

Corning Union Elementary SD - CLASSIFIED

October 1, 2026 - September 30, 2027

BENEFIT	PPO 1, Rx A	PPO 4, Rx A	PPO 8, Rx A	PPO 10, Rx A
Calendar Year Deductible	\$0	Individual: \$150 Family: \$300	Individual: \$500 Family: \$1,000	Individual: \$2,000 Family: \$4,000
Coinsurance	Paid at 100%*	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Calendar Year Out of Pocket Maximum (includes medical/pharmacy deductible, coinsurance, and copays) ⁽²⁾	Individual: \$1,500 ⁽²⁾ Family: \$3,000 ⁽²⁾	Individual: \$2,500 ⁽²⁾ Family: \$5,000 ⁽²⁾	Individual: \$4,500 ⁽²⁾ Family: \$9,000 ⁽²⁾	Individual: \$6,500 ⁽²⁾ Family: \$13,000 ⁽²⁾
Doctor Visits	Primary Care Physician - \$10 Copay Specialist Physician - \$20 Copay	Primary Care Physician - \$20 Copay Specialist Physician - \$40 Copay	Primary Care Physician - \$30 Copay Specialist Physician - \$60 Copay	Paid at 80%* after deductible is met
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Laboratory	Non-Hospital - Paid at 100%* Hospital - \$50 copay, then paid at 100%*	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$50 copay then paid at 90%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$50 copay then paid at 80%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$50 copay then paid at 80%*
Outpatient Radiology	Non-Hospital - Paid at 100%* Hospital - \$75 copay, then paid at 100%*	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$75 copay then paid at 90%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$75 copay then paid at 80%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$75 copay then paid at 80%*
Durable Medical Equipment	Paid at 100%*	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Ambulance - Ground / Air	Paid at 100%* of covered charges	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Physical Therapy	Paid at 100%* ⁽¹⁾ (Copay, if applicable.)	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.)
Chiropractic	Paid at 100%* ⁽¹⁾ (Copay, if applicable.)	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.)
Acupuncture	Paid at 100%* (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	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
Outpatient Surgery	Non-Hospital - Paid at 100%* Hospital - \$250 copay, then paid at 100%*	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$250 copay then paid at 90%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$250 copay then paid at 80%*	Non-Hospital - Paid at 80%* after deductible is met Hospital - After deductible is met, \$250 copay then paid at 80%*
Hospital Inpatient	Paid at 100%* Unlimited days, Semi-private room	Paid at 90%* after deductible is met; Unlimited days, Semi-private room	Paid at 80%* after deductible is met; Unlimited days, Semi-private room	Paid at 80%* after deductible is met; Unlimited days, Semi-private room
Hospital Emergency Room	\$200 Copay (Copay waived if admitted as inpatient) After copay, paid at 100%*	\$200 Copay (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 90%*	\$200 Copay (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 80%*	\$200 Copay (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 80%*
Urgent Care	\$10 Copay	\$20 Copay	\$30 Copay	Paid at 80%* after deductible is met
Home Health Care	Paid at 100%* Limited to 100 visits per calendar year	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

BENEFIT	PPO 1, Rx A		PPO 4, Rx A		PPO 8, Rx A		PPO 10, Rx A	
Telehealth	MDLIVE - Paid at 100%* for non-emergency medical, dermatology, behavioral health, and primary care visits. ⁽²⁾ Call 1-888-632-2738 or visit www.mdlive.com/CVT		MDLIVE - Paid at 100%* for non-emergency medical, dermatology, behavioral health, and primary care visits. ⁽²⁾ Call 1-888-632-2738 or visit www.mdlive.com/CVT		MDLIVE - Paid at 100%* for non-emergency medical, dermatology, behavioral health, and primary care visits. ⁽²⁾ Call 1-888-632-2738 or visit www.mdlive.com/CVT		MDLIVE - Paid at 100%* for non-emergency medical, dermatology, behavioral health, and primary care visits. ⁽²⁾ Call 1-888-632-2738 or visit www.mdlive.com/CVT	
Virtual Physical Therapy	Paid at 100%. Call 1-800-644-2478 for virtual musculoskeletal (MSK) benefits by SimpleTherapy .		Paid at 100%. Call 1-800-644-2478 for virtual musculoskeletal (MSK) benefits by SimpleTherapy .		Paid at 100%. Call 1-800-644-2478 for virtual musculoskeletal (MSK) benefits by SimpleTherapy .		Paid at 100%. Call 1-800-644-2478 for virtual musculoskeletal (MSK) benefits by SimpleTherapy .	
Employee Assistance Program (EAP) through Carelon	Paid at 100% - Visit www.carelonwellbeing.com/cvt or call 1-877-397-1032 to access benefit ⁽³⁾		Paid at 100% - Visit www.carelonwellbeing.com/cvt or call 1-877-397-1032 to access benefit ⁽³⁾		Paid at 100% - Visit www.carelonwellbeing.com/cvt or call 1-877-397-1032 to access benefit ⁽³⁾		Paid at 100% - Visit www.carelonwellbeing.com/cvt or call 1-877-397-1032 to access benefit ⁽³⁾	
Prescription Drugs	30-Day Supply ^(4, 9) Generic: \$5 Pref Brand: \$22 Non-Pref Brand: \$22 Specialty: Paid at 70%, \$0 when enrolled in Prudent Rx	90-Day Supply ^(4, 9) Generic: \$10 Pref Brand: \$44 Non-Pref Brand: \$44 Specialty: N/A	30-Day Supply ^(4, 9) Generic: \$5 Pref Brand: \$22 Non-Pref Brand: \$22 Specialty: Paid at 70%, \$0 when enrolled in Prudent Rx	90-Day Supply ^(4, 9) Generic: \$10 Pref Brand: \$44 Non-Pref Brand: \$44 Specialty: N/A	30-Day Supply ^(4, 9) Generic: \$5 Pref Brand: \$22 Non-Pref Brand: \$22 Specialty: Paid at 70%, \$0 when enrolled in Prudent Rx	90-Day Supply ^(4, 9) Generic: \$10 Pref Brand: \$44 Non-Pref Brand: \$44 Specialty: N/A	30-Day Supply ^(4, 9) Generic: \$5 Pref Brand: \$22 Non-Pref Brand: \$22 Specialty: Paid at 70%, \$0 when enrolled in Prudent Rx	90-Day Supply ^(4, 9) Generic: \$10 Pref Brand: \$44 Non-Pref Brand: \$44 Specialty: N/A

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. Anthem BDC+ required procedures excluded from \$250 outpatient surgery copay.

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

(2) Retired members enrolled in Medicare: (1) MDLIVE Behavioral Health visits are excluded (2) The PrudentRx program is not applicable and pharmacy cost share will not apply to out of pocket maximums (3) CVT PPO Plans 1-10 pay according to non-duplication of Medicare benefits therefore those plan designs are inclusive of Medicare's payment.

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

(4) If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for specialty medications will be \$0. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for your specialty medications.

(9) For GLP-1 information, visit **www.cvtrust.org/glp1**

This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits at **www.cvtrust.org/plan-documents**.

CVT PPO Health Plans with Anthem Blue Cross and CVS/caremark

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BENEFIT	Wellness, Rx C	HDHP 2	Bronze
Calendar Year Deductible	Individual: \$500 Family: \$1,000	Individual: \$2,600 Family: \$5,200 (No individual limit applies to family)	Individual: \$5,000 Family: \$10,000
Coinsurance	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 70%* after deductible is met
Calendar Year Out of Pocket Maximum (includes medical/pharmacy deductible, coinsurance, and copays) ⁽²⁾	Individual: \$3,500 Family: \$7,000	Individual: \$6,000 Family: \$12,000 Family = Employee with 1 or more covered dependents. No one individual will pay more than \$6,000.	Individual: \$7,000 Family: \$14,000
Doctor Visits	Primary Care Physician - \$20 Copay Specialist Physician - \$40 Copay	Primary Care Physician - Paid at 80%* after deductible is met Specialist Physician - Paid at 80% after deductible is met	Primary Care Physician - First 3 visits covered in full after \$60 copay per visit; Remaining visits - Paid at 70%* after deductible is met Specialist Physician - Subject to deductible then \$120 copay per visit
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Laboratory	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$50 copay then paid at 90%*	Paid at 80%* after deductible is met	Paid at 70%* after deductible is met
Outpatient Radiology	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$75 copay then paid at 90%*	Paid at 80%* after deductible is met	Paid at 70%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 70%* after deductible is met
Ambulance - Ground / Air	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 70%* 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	Paid at 70%* ⁽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	Paid at 70%* ⁽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. Maximum of 12 visits per calendar year	Paid at 70%* after deductible is met (Copay, if applicable). Maximum of 12 visits per calendar year
Outpatient Surgery	Non-Hospital - Paid at 90%* after deductible is met Hospital - After deductible is met, \$250 copay then paid at 90%*	Paid at 80%* after deductible is met	Paid at 70%* after deductible is met
Hospital Inpatient	Paid at 90%* after deductible is met; Unlimited days, Semi-private room	Paid at 80%* after deductible is met; Unlimited days, Semi-private room	Paid at 70%* after deductible is met; Unlimited days, Semi-private room
Hospital Emergency Room	\$200 Copay; (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 90%*	Paid at 80%* after deductible is met	Subject to Deductible, then \$200 Copay (copay waived if admitted as inpatient)
Urgent Care	\$20 Copay	Paid at 80%* after deductible is met	Subject to deductible, then \$120 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 70%* after deductible is met; Limited to 100 visits per calendar year

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Prescription Drugs	30-Day Supply ^(4, 9) Generic: \$7 Pref Brand: \$25 Non-Pref Brand: \$40 Specialty: Paid at 70%, \$0 when enrolled in Prudent Rx	90-Day Supply ^(4, 9) Generic: \$15 Pref Brand: \$60 Non-Pref Brand: \$90 Specialty: N/A	30-Day Supply Subject to deductible, then Generic: \$25 Copay Pref Brand: \$50 Copay Non-Pref Brand: \$50 Copay Specialty: Paid at 70%, reduced to \$0 after deductible when enrolled in PrudentRx	90-Day Supply Subject to deductible, then Generic: \$50 Copay Pref Brand: \$100 Copay Non-Pref Brand: \$100 Copay Specialty: N/A	30-Day Supply Subject to deductible, then Generic: \$25 Copay Pref Brand: \$50 Copay Non-Pref Brand: \$50 Copay Specialty: Paid at 70%, \$0 when enrolled in PrudentRx	90-Day Supply Subject to deductible, then Generic: \$50 Copay Pref Brand: \$100 Copay Non-Pref Brand: \$100 Copay Specialty: N/A

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