Open Enrollment

Effective Date: October 1, 2021

CVT's team will be available to meet with you one-on-one over the phone, or even via video conference, to walk you through your open enrollment selections and answer any questions you might have about:

- The benefit choices available, and how best to select a medical plan that meets the needs of you and your family
- How to save time and money for non-emergent care using MDLIVE® telehealth program
- Navigating through the complexities of health insurance, and how CVT can tie resources to getting you the quality care you need

During Open Enrollment, an employee is allowed to do the following:

- Elect to change his or her medical plan selection and participate in a different plan
- A full time or part time employee may terminate or add eligible dependents to medical, vision or dental coverage. Adding eligible dependents require documentation (marriage/birth certificate, etc.)
- A part time employee may terminate or add medical, vision or dental coverage.
- Employees can opt out of health insurance who are eligible for Medi-CAL, TRICARE, or subsidized Covered CA.

Oak Park Unified School District OPEN ENROLLMENT PERIOD

July 12, 2021
through
August 13, 2021

CVT's Representative will be available by phone or video conference:

August 4, 2021
8:00 a.m. – 1:00 p.m.
https://calendly.com/elizabethp-3/oak-park-open-enrollment

&

August 11, 2021
12:00 p.m. – 5:00 p.m.
https://calendly.com/elizabethp-3/oak-park-open-enrollment

Open enrollment changes must be submitted online:
mycvt.cvtrust.org

Please note: If you are not making any changes, you do not need to take any action.

Questions?

Contact:
Linda Castellano
831-755-3220
lcastellano@opusd.org

CVT Contact:

Member Services Department

1-800-288-9870

California's Valued Trust
Healthcare Benefits for the Education Community

MyCVT Online Member Enrollment

Quick steps for account set-up

MyCVT is a web-based site where you can enroll as a new member of California's Valued Trust (CVT), choose a plan from several options that have been selected by your district or unit and make changes to your plan such as adding dependents or a change of address.

MyCVT can be accessed by most computer browsers, including Microsoft Internet Explorer Version 7-11, Mozilla Firefox, Safari and Goggle Chrome. If you don't have any of these browsers you may not be able to access the site.

Getting started

1. To access the site directly from your browser, type: https://mycvt.cvtrust.org.
2. You may also access the portal from www.cvtrust.org. Click on the MyCVT logo in the upper, right-hand corner of the page.
3. You will need the following information to create your account:
    - Unique email address (you cannot use a shared or group email)
    - Social Security number (do not use dashes in the form)
    - Your district name and classification
    - Password (six-digits minimum)
    - Date of Birth

Creating your account

1. From the MyCVT registration page, select "Create new account." Complete the requested information and submit.
2. Verify your date of birth.
3. A registration link will be sent to the unique email you submitted.
4. **Click on the link in the email** to complete the registration process.

You're ready to go!

1. Now you're logged into the MyCVT portal and are ready to complete your member enrollment.
2. Or, if you want to come back later and complete enrollment, simply log-out. When you're ready to return, use your newly set up Email and Password to access your account.
3. If you've forgotten your password, don't worry. Select "Request new password" on the login page and follow the directions sent to your account email.

Questions

If you have any questions about how to create your account, help is only a phone call away. Contact your district office or CVT Member Services at 800-288-9870

CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community

www.cvtrust.org

CALIFORNIA'S VALUED TRUST

2021/2022 District Rate Sheet

For Oak Park Unified SD

CERTIFICATED Active	Empl Only	Empl+One	Empl+Family	Pct
Health Three Tier Rates	2021/2022	2021/2022	2021/2022	Chg
CVT Bronze Plan	$495.00	$851.00	$1,074.00	4.2%
HDHP 1, RX-H1	$597.00	$1,026.00	$1,295.00	3.9%
KS 1 Active Chiro	$681.16	$1,173.31	$1,481.84	5.0%
KS 2 Active Chiro	$663.16	$1,141.31	$1,441.84	5.0%
KS 6 Active Chiro	$637.16	$1,097.31	$1,385.84	4.9%
PPO-1, RX-B	$1,076.00	$1,850.00	$2,335.00	4.0%
PPO-3, RX-B	$994.00	$1,709.00	$2,157.00	4.0%
PPO-5, RX-B	$945.00	$1,625.00	$2,050.00	4.0%
PPO-7, RX-B	$871.00	$1,498.00	$1,890.00	4.0%
WELL-1, RX-C	$891.00	$1,532.00	$1,934.00	4.2%

CERTIFICATED Active	Empl Only	Empl+One	Empl+Family	Pct
Dental Three Tier Rates	2021/2022	2021/2022	2021/2022	Chg
Basic, $2,000 Annual Maximum, Ortho 50/50 Adults & Children $1,000 Lifetime Max	$57.00	$105.44	$162.37	0.0%

CERTIFICATED Active	Empl Only	Empl+One	Empl+Family	Pct
Vision Three Tier Rates	2021/2022	2021/2022	2021/2022	Chg
Plan B $15.00 Copay	$7.28	$13.53	$20.84	0.0%

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

Oak Park Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2021 - September 30, 2022

BENEFIT	PPO 1B	PPO 3B	PPO 5B	PPO 7B
Calendar Year Deductible	$0	Individual: $100 Family: $200	Individual: $100 Family: $200	Individual: $250 Family: $500
Coinsurance	Paid at 100%*	Paid at 100%* after deductible is met	Paid at 90%* 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: $1,250 Family: $2,500	Individual: $1,250 Family: $2,500	Individual: $1,250 Family: $2,500	Individual: $2,000 Family: $4,000
Doctor Visits	**Primary Care Physician** - $10 Copay **Specialty Physician** - $10 Copay	**Primary Care Physician** - $20 Copay **Specialty Physician** - $20 Copay	**Primary Care Physician** - $30 Copay **Specialty Physician** - $30 Copay	**Primary Care Physician** - $30 Copay **Specialty Physician** - $30 Copay
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 100%* after deductible is met **Hospital** - After deductible is met, $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%*
Outpatient Radiology	**Non-Hospital** - Paid at 100%* **Hospital** - $75 copay, then paid at 100%*	**Non-Hospital** - Paid at 100%* after deductible is met **Hospital** - After deductible is met, $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%*
Durable Medical Equipment	Paid at 100%*	Paid at 100%* after deductible is met	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met
Ambulance - Ground / Air	Paid at 100%* of covered charges	Paid at 100%* after deductible is met	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met
Physical Therapy	Paid at 100%*(1) (Copay, if applicable.)	Paid at 100%*(1) after deductible is met (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.)
Chiropractic	Paid at 100%*(1) (Copay, if applicable.)	Paid at 100%*(1) after deductible is met (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.)
Acupuncture	Paid at 100%* (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 100%* 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	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 100%* after deductible is met **Hospital** - After deductible is met, $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%*
Hospital Inpatient	Paid at 100%* Unlimited days, Semi-private room	Paid at 100%* after deductible is met; 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
Hospital Emergency Room	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After copay, paid at 100%*	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 100%*	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 90%*	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 80%*
Urgent Care	$10 Copay	$20 Copay	$30 Copay	$30 Copay
Home Health Care	Paid at 100%* Limited to 100 visits per calendar year	Paid at 100%* 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	Paid at 80%* after deductible is met; Limited to 100 visits per calendar year

BENEFIT	PPO 1B		PPO 3B		PPO 5B		PPO 7B	
Telehealth	MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations.(2) Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations.(2) Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations.(2) Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations.(2) Call **1-888-632-2738** or visit **www.mdlive.com/CVT**	
Medical Decision Support	Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance		Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance		Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance		Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance	
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(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**(4) $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order**(4) $15 Generic $35 Preferred $70 Non-Preferred (90-Day Supply)	**Retail**(4) $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order**(4) $15 Generic $35 Preferred $70 Non-Preferred (90-Day Supply)	**Retail**(4) $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order**(4) $15 Generic $35 Preferred $70 Non-Preferred (90-Day Supply)	**Retail**(4) $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order**(4) $15 Generic $35 Preferred $70 Non-Preferred (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) Retired members enrolled in Medicare: (1) MDLIVE Behavioral Health and Consumer Medical visits are excluded (2) 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) Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for prescription plans A, B, C (includes Wellness), D and ValuRx

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

Oak Park Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2021 - September 30, 2022

BENEFIT	PPO Wellness	HDHP 1	PPO Bronze
Calendar Year Deductible	Individual: $500 Family: $1,000	Individual: $1,400 Family: $2,800 (No individual limit applies to family)	Individual: $5,000 Family: $10,000
Coinsurance	Paid at 90%* after deductible is met	Paid at 90%* 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: $1,750 Family: $3,500	Individual: $4,250 Family: $8,500 Family = Employee with 1 or more covered dependents. No one individual will pay more than $6,900.	Individual: $6,350 Family: $12,700
Doctor Visits	**Primary Care Physician** - $20 Copay **Specialty Physician** - $40 Copay	Paid at 90%* 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 **Specialty Physician** - Subject to deductible then $70 copay
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 90%* 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 90%* after deductible is met	Paid at 70%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met	Paid at 90%* after deductible is met	Paid at 70%* after deductible is met
Ambulance - Ground / Air	Paid at 90%* after deductible is met	Paid at 90%* 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 90%*(1) after deductible is met	Paid at 70%*(1) after deductible is met
Chiropractic	Paid at 90%*(1) after deductible is met (Copay, if applicable.)	Paid at 90%*(1) after deductible is met	Paid at 70%*(1) after deductible is met
Acupuncture	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 90%* after deductible is met. Maximum of 12 visits per calendar year	Paid at 70%* after deductible is met 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 90%* 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 90%* after deductible is met; Unlimited days, Semi-private room	Paid at 70%* after deductible is met; Unlimited days, Semi-private room
Hospital Emergency Room	**$100 Emergent Copay;** **$175 Non-Emergent Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 90%*	Paid at 90%* after deductible is met	Subject to Deductible, then $250 Copay (copay waived if admitted as in-patient)
Urgent Care	$20 Copay	Paid at 90%* 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 90%* 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

BENEFIT	PPO Wellness		HDHP 1	PPO Bronze	
Telehealth	MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations. Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 90%* after deductible is met Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical and dermatology conditions and Behavioral Health.	MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations. Call **1-888-632-2738** or visit **www.mdlive.com/CVT**	
Medical Decision Support	Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance		Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance	Consumer Medical - Your Medical Ally **Call 1-888-361-3944** or visit **myconsumermedical.com** for expert medical guidance	
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(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**(4) $7 Generic $25 Pref $40 Non-Pref (30-Day Supply)	**Mail Order**(4) $15 Generic $60 Pref $90 Non-Pref (90-Day Supply)	Paid at 90%* after deductible is met	**Retail**(4) Subject to deductible, then $25 Generic Copay $50 Brand Copay (30-Day Supply)	**Mail Order**(4) Subject to deductible, then $50 Generic Copay $100 Brand Copay (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) Retired members enrolled in Medicare: (1) MDLIVE Behavioral Health and Consumer Medical visits are excluded (2) 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) Copays for certain specialty medications may be set to available manufacturer-funded copay assistance for prescription plans A, B, C (includes Wellness), D and ValuRx

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

CVT HMO Health Plans with Kaiser Permanente

Oak Park Unified SD - CERTIFICATED, CLASSIFIED, MANAGEMENT, TRUSTEES

October 1, 2021 - September 30, 2022

BENEFIT	Kaiser 1 W / CHIRO		Kaiser 2 W / CHIRO		Kaiser 6 W / CHIRO	
Calendar Year Deductible	$0		$0		$0	
Coinsurance	Paid at 100%*		Paid at 100%*		Paid at 100%*	
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	
Doctor Visits	**Primary Care Physician** - $10 Copay **Specialty Physician** - $10 Copay		**Primary Care Physician** - $15 Copay **Specialty Physician** - $15 Copay		**Primary Care Physician** - $25 Copay **Specialty Physician** - $25 Copay	
Preventive Care / Immunizations	Paid at 100%*		Paid at 100%*		Paid at 100%*	
Outpatient Laboratory	Paid at 100%*		Paid at 100%*		Paid at 100%*	
Outpatient Radiology	Radiation Therapy:Paid at 100%* Chemotherapy:$10 Copay		Radiation Therapy:Paid at 100%* Chemotherapy:$15 Copay		Radiation Therapy:Paid at 100%* Chemotherapy:$25 Copay	
Durable Medical Equipment	Paid at 100%*		Paid at 100%*		Paid at 100%*	
Ambulance - Ground / Air	Paid at 100%* If Medically Necessary		Paid at 100%* If Medically Necessary		$50 Per Trip If Medically Necessary	
Physical Therapy	$10 Copay		$15 Copay		$25 Copay	
Chiropractic	Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Acupuncture		Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Acupuncture		Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Acupuncture	
Acupuncture	Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Chiropractic		Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Chiropractic		Benefit through PhysMetrics; $10 office visit copay; $15 daily max for out of network; Up to 40 visits per year combined with Chiropractic	
Outpatient Surgery	$10 Copay		$15 Copay		$25 Copay	
Hospital Inpatient	Paid at 100%*		Paid at 100%*		$250 Copay	
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	
Urgent Care	$10 Copay		$15 Copay		$25 Copay	
Home Health Care	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**	
Medical Decision Support	N/A		N/A		N/A	
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[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** $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)

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.

California's Valued Trust
Healthcare Benefits for the Education Community

Oak Park Unified School District

Delta Dental PPO Incentive Plan Summary of Benefits

Effective October 1, 2021 to September 30, 2022

Benefits and Covered Services*	PPO Network **	Premier Network and Out of Network **
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	$2,200	$2,000
Diagnostic & Preventive Services Oral Examinations: 2 Annual Cleanings: 2 X-rays	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Basic Services Fillings Posterior Composite Restorations Sealants	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Periodontics (gum treatment) Covered Under Basic Services	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Endodontics (root canals)	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Oral Surgery (extraction) Covered Under Basic Services	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Major Services Crowns, Inlays, Onlays & Cast Restorations	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Prosthodontics Bridges Dentures Implants	Paid at: 50% *	Paid at: 50% *
Orthodontic Benefits Adults & Dependent Children Lifetime Maximum: $1,000 12 Month Wait: No	Paid at: 50% *	Paid at: 50% *
Dental Accident Benefits	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)

*** This summary is for comparison purposes only. The Evidence of Coverage should be consulted for a detailed description of the covered benefits and is available at www.cvtrust.org/plandocuments.**

** See back for additional details

What are my Delta Dental Network options?

The Delta Dental PPO plan allows you the option to visit any licensed dentist. You will usually save more on your out-of-pocket costs when you visit a **Delta Dental PPO** dentist. The **Delta Dental Premier** network also provides cost-saving features and is the next best option when you can't find a PPO dentist. Non-Delta Dental (Out of Network) dentists have no fee agreements with Delta Dental, so you will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist. You are responsible for the difference between what Delta Dental pays and the dentist's fee.

How do I find a Delta Dental dentist?

To locate a Delta Dental dentist near you, check the dentist directory on the Delta Dental website **(deltadentalins.com)**, which also provides a map to the dental office. Or, to hear or receive a faxed listing of dentists in your area, call **866-499-3001**. Follow the automated instructions to search for a dentist.

How does my Delta Dental incentive plan work?

Your dental benefit incentive plan is designed to encourage regular visits to the dentist to keep your teeth and gums healthy. Here is an example of how an incentive plan works. (This is the most common incentive plan. Check your benefits information for details of your particular incentive plan.)

First Year	Second Year	Third Year	Fourth Year
70%	80%	90%	100%

Percentage paid for certain benefits
as long as you visit the dentist each year.

What are my online resources?

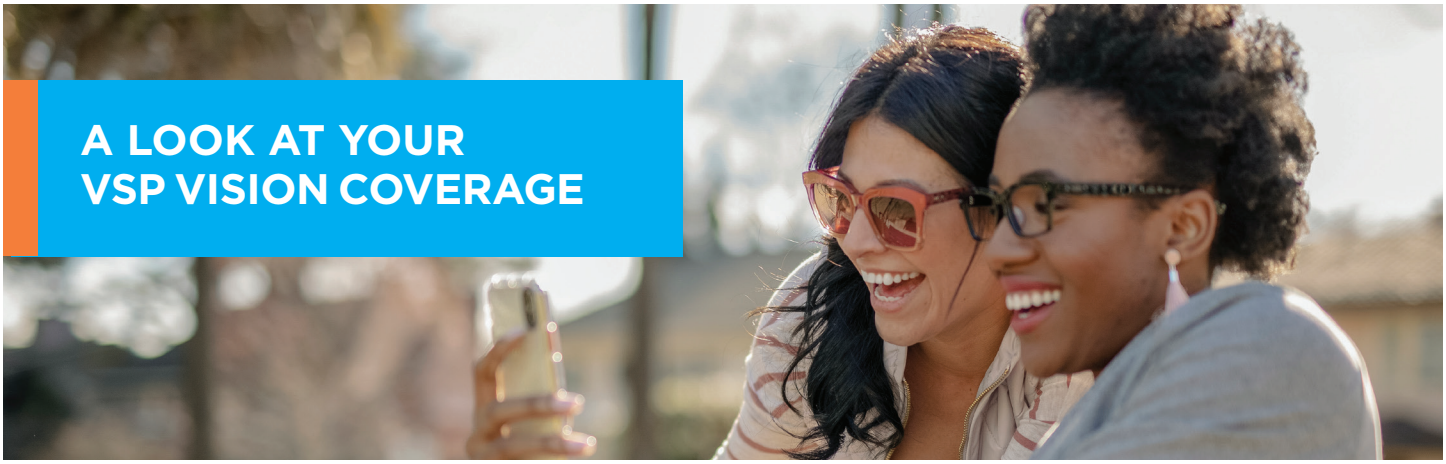
The full Delta Dental website is a one-stop-shop for plan and oral health information.
Also available in Spanish: **es.deltadentalins.com**.

Create a free Online Services account at **deltadentalins.com** to:

- Locate a Delta Dental dentist
- Check benefits, eligibility, and claim status
- Opt for paperless statements
- View or print your ID card
- Check average dental costs in your area

Check out **Your Dental Plan Support Guide** for money-saving tips and treatment information. And, don't miss **mysmileway.com** – a great resource for oral health-related tools and tips.

Mobile? Get the information you need on the go. Bookmark or add a shortcut to the mobile site to return in just one tap from your phone. Download the free, convenient smartphone Delta Dental app from the App Store or Google Play.



A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM CALIFORNIA'S VALUED TRUST PLAN B $15.00 COPAY AND VSP.

VSP Vision Care | California's Valued Trust — Healthcare Benefits for the Education Community

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

PREMIER PROGRAM

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

+ UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
2021-2022
Oak Park Unified School District

California's Valued Trust
Healthcare Benefits for the Education Community

VSP Vision care for life

PROVIDER NETWORK: VSP Signature

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$15.00 for exam and glasses	Every 12 months
PRESCRIPTION GLASSES			
FRAME	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit vsp.com for details. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

CVT Benefits Plan

Anthem Blue Cross PPO Plan 1B

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			THE COST OF PREMIUMS WILL BE:				1.0 FTE PAYROLL DEDUCTION			0.9 FTE PAYROLL DEDUCTION		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	12,912.00	684.00	87.36	13,683.36	$9,127.00	4,556.36	455.64	8,214.30	5,469.06	546.91
Employee Only	Emp+1	Emp+1	12,912.00	1,265.28	162.36	14,339.64	$9,127.00	5,212.64	521.26	8,214.30	6,125.34	612.53
Employee Only	Family	Family	12,912.00	1,948.44	250.08	15,110.52	$9,127.00	5,983.52	598.35	8,214.30	6,896.22	689.62
Employee+1 Dependent	Emp	Emp	22,200.00	684.00	87.36	22,971.36	$15,020.00	7,951.36	795.14	13,518.00	9,453.36	945.34
Employee+1 Dependent	Emp+1	Emp+1	22,200.00	1,265.28	162.36	23,627.64	$15,020.00	8,607.64	860.76	13,518.00	10,109.64	1,010.96
Employee+1 Dependent	Family	Family	22,200.00	1,948.44	250.08	24,398.52	$15,020.00	9,378.52	937.85	13,518.00	10,880.52	1,088.05
Family Coverage	Emp	Emp	28,020.00	684.00	87.36	28,791.36	$19,127.00	9,664.36	966.44	17,214.30	11,577.06	1,157.71
Family Coverage	Emp+1	Emp+1	28,020.00	1,265.28	162.36	29,447.64	$19,127.00	10,320.64	1,032.06	17,214.30	12,233.34	1,223.33
Family Coverage	Family	Family	28,020.00	1,948.44	250.08	30,218.52	$19,127.00	11,091.52	1,109.15	17,214.30	13,004.22	1,300.42

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			0.8 FTE PAYROLL DEDUCTION			0.75 FTE PAYROLL DEDUCTION			0.60 FTE PAYROLL DEDUCTION			0.50 FTE PAYROLL DEDUCTION		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	6,381.76	638.18	6,845.25	6,838.11	683.81	5,476.20	8,207.16	820.72	4,563.50	9,119.86	911.99
Employee Only	Emp+1	Emp+1	7,301.60	7,038.04	703.80	6,845.25	7,494.39	749.44	5,476.20	8,863.44	886.34	4,563.50	9,776.14	977.61
Employee Only	Family	Family	7,301.60	7,808.92	780.89	6,845.25	8,265.27	826.53	5,476.20	9,634.32	963.43	4,563.50	10,547.02	1,054.70
Employee+1 Dependent	Emp	Emp	12,016.00	10,955.36	1,095.54	11,265.00	11,706.36	1,170.64	9,012.00	13,959.36	1,395.94	7,510.00	15,461.36	1,546.14
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	11,611.64	1,161.16	11,265.00	12,362.64	1,236.26	9,012.00	14,615.64	1,461.56	7,510.00	16,117.64	1,611.76
Employee+1 Dependent	Family	Family	12,016.00	12,382.52	1,238.25	11,265.00	13,133.52	1,313.35	9,012.00	15,386.52	1,538.65	7,510.00	16,888.52	1,688.85
Family Coverage	Emp	Emp	15,301.60	13,489.76	1,348.98	14,345.25	14,446.11	1,444.61	11,476.20	17,315.16	1,731.52	9,563.50	19,227.86	1,922.79
Family Coverage	Emp+1	Emp+1	15,301.60	14,146.04	1,414.60	14,345.25	15,102.39	1,510.24	11,476.20	17,971.44	1,797.14	9,563.50	19,884.14	1,988.41
Family Coverage	Family	Family	15,301.60	14,916.92	1,491.69	14,345.25	15,873.27	1,587.33	11,476.20	18,742.32	1,874.23	9,563.50	20,655.02	2,065.50

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Anthem Blue Cross PPO Plan 3B

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			THE COST OF PREMIUMS WILL BE:				1.0 FTE PAYROLL DEDUCTION			0.9 FTE PAYROLL DEDUCTION		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	Dental	Vision	Medical	Dental	Vision	Total	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	11,928.00	684.00	87.36	12,699.36	$9,127.00	3,572.36	357.24	8,214.30	4,485.06	448.51
Employee Only	Emp+1	Emp+1	11,928.00	1,265.28	162.36	13,355.64	$9,127.00	4,228.64	422.86	8,214.30	5,141.34	514.13
Employee Only	Family	Family	11,928.00	1,948.44	250.08	14,126.52	$9,127.00	4,999.52	499.95	8,214.30	5,912.22	591.22
Employee+1 Dependent	Emp	Emp	20,508.00	684.00	87.36	21,279.36	$15,020.00	6,259.36	625.94	13,518.00	7,761.36	776.14
Employee+1 Dependent	Emp+1	Emp+1	20,508.00	1,265.28	162.36	21,935.64	$15,020.00	6,915.64	691.56	13,518.00	8,417.64	841.76
Employee+1 Dependent	Family	Family	20,508.00	1,948.44	250.08	22,706.52	$15,020.00	7,686.52	768.65	13,518.00	9,188.52	918.85
Family Coverage	Emp	Emp	25,884.00	684.00	87.36	26,655.36	$19,127.00	7,528.36	752.84	17,214.30	9,441.06	944.11
Family Coverage	Emp+1	Emp+1	25,884.00	1,265.28	162.36	27,311.64	$19,127.00	8,184.64	818.46	17,214.30	10,097.34	1,009.73
Family Coverage	Family	Family	25,884.00	1,948.44	250.08	28,082.52	$19,127.00	8,955.52	895.55	17,214.30	10,868.22	1,086.82

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			0.8 FTE PAYROLL DEDUCTION			0.75 FTE PAYROLL DEDUCTION			0.60 FTE PAYROLL DEDUCTION			0.50 FTE PAYROLL DEDUCTION		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	Dental	Vision	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	5,397.76	539.78	6,845.25	5,854.11	585.41	5,476.20	7,223.16	722.32	4,563.50	8,135.86	813.59
Employee Only	Emp+1	Emp+1	7,301.60	6,054.04	605.40	6,845.25	6,510.39	651.04	5,476.20	7,879.44	787.94	4,563.50	8,792.14	879.21
Employee Only	Family	Family	7,301.60	6,824.92	682.49	6,845.25	7,281.27	728.13	5,476.20	8,650.32	865.03	4,563.50	9,563.02	956.30
Employee+1 Dependent	Emp	Emp	12,016.00	9,263.36	926.34	11,265.00	10,014.36	1,001.44	9,012.00	12,267.36	1,226.74	7,510.00	13,769.36	1,376.94
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	9,919.64	991.96	11,265.00	10,670.64	1,067.06	9,012.00	12,923.64	1,292.36	7,510.00	14,425.64	1,442.56
Employee+1 Dependent	Family	Family	12,016.00	10,690.52	1,069.05	11,265.00	11,441.52	1,144.15	9,012.00	13,694.52	1,369.45	7,510.00	15,196.52	1,519.65
Family Coverage	Emp	Emp	15,301.60	11,353.76	1,135.38	14,345.25	12,310.11	1,231.01	11,476.20	15,179.16	1,517.92	9,563.50	17,091.86	1,709.19
Family Coverage	Emp+1	Emp+1	15,301.60	12,010.04	1,201.00	14,345.25	12,966.39	1,296.64	11,476.20	15,835.44	1,583.54	9,563.50	17,748.14	1,774.81
Family Coverage	Family	Family	15,301.60	12,780.92	1,278.09	14,345.25	13,737.27	1,373.73	11,476.20	16,606.32	1,660.63	9,563.50	18,519.02	1,851.90

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Anthem Blue Cross PPO Plan 5B

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			THE COST OF PREMIUMS WILL BE:				1.0 FTE PAYROLL DEDUCTION			0.9 FTE PAYROLL DEDUCTION		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	Dental	Vision	Medical	Dental	Vision	Total	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	11,340.00	684.00	87.36	12,111.36	$9,127.00	2,984.36	298.44	8,214.30	3,897.06	389.71
Employee Only	Emp+1	Emp+1	11,340.00	1,265.28	162.36	12,767.64	$9,127.00	3,640.64	364.06	8,214.30	4,553.34	455.33
Employee Only	Family	Family	11,340.00	1,948.44	250.08	13,538.52	$9,127.00	4,411.52	441.15	8,214.30	5,324.22	532.42
Employee+1 Dependent	Emp	Emp	19,500.00	684.00	87.36	20,271.36	$15,020.00	5,251.36	525.14	13,518.00	6,753.36	675.34
Employee+1 Dependent	Emp+1	Emp+1	19,500.00	1,265.28	162.36	20,927.64	$15,020.00	5,907.64	590.76	13,518.00	7,409.64	740.96
Employee+1 Dependent	Family	Family	19,500.00	1,948.44	250.08	21,698.52	$15,020.00	6,678.52	667.85	13,518.00	8,180.52	818.05
Family Coverage	Emp	Emp	24,600.00	684.00	87.36	25,371.36	$19,127.00	6,244.36	624.44	17,214.30	8,157.06	815.71
Family Coverage	Emp+1	Emp+1	24,600.00	1,265.28	162.36	26,027.64	$19,127.00	6,900.64	690.06	17,214.30	8,813.34	881.33
Family Coverage	Family	Family	24,600.00	1,948.44	250.08	26,798.52	$19,127.00	7,671.52	767.15	17,214.30	9,584.22	958.42

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			0.8 FTE PAYROLL DEDUCTION			0.75 FTE PAYROLL DEDUCTION			0.60 FTE PAYROLL DEDUCTION			0.50 FTE PAYROLL DEDUCTION		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	Dental	Vision	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	4,809.76	480.98	6,845.25	5,266.11	526.61	5,476.20	6,635.16	663.52	4,563.50	7,547.86	754.79
Employee Only	Emp+1	Emp+1	7,301.60	5,466.04	546.60	6,845.25	5,922.39	592.24	5,476.20	7,291.44	729.14	4,563.50	8,204.14	820.41
Employee Only	Family	Family	7,301.60	6,236.92	623.69	6,845.25	6,693.27	669.33	5,476.20	8,062.32	806.23	4,563.50	8,975.02	897.50
Employee+1 Dependent	Emp	Emp	12,016.00	8,255.36	825.54	11,265.00	9,006.36	900.64	9,012.00	11,259.36	1,125.94	7,510.00	12,761.36	1,276.14
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	8,911.64	891.16	11,265.00	9,662.64	966.26	9,012.00	11,915.64	1,191.56	7,510.00	13,417.64	1,341.76
Employee+1 Dependent	Family	Family	12,016.00	9,682.52	968.25	11,265.00	10,433.52	1,043.35	9,012.00	12,686.52	1,268.65	7,510.00	14,188.52	1,418.85
Family Coverage	Emp	Emp	15,301.60	10,069.76	1,006.98	14,345.25	11,026.11	1,102.61	11,476.20	13,895.16	1,389.52	9,563.50	15,807.86	1,580.79
Family Coverage	Emp+1	Emp+1	15,301.60	10,726.04	1,072.60	14,345.25	11,682.39	1,168.24	11,476.20	14,551.44	1,455.14	9,563.50	16,464.14	1,646.41
Family Coverage	Family	Family	15,301.60	11,496.92	1,149.69	14,345.25	12,453.27	1,245.33	11,476.20	15,322.32	1,532.23	9,563.50	17,235.02	1,723.50

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Anthem Blue Cross PPO Plan 7B

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	10,452.00	684.00	87.36	11,223.36	$9,127.00	2,096.36	209.64	8,214.30	3,009.06	300.91
Employee Only	Emp+1	Emp+1	10,452.00	1,265.28	162.36	11,879.64	$9,127.00	2,752.64	275.26	8,214.30	3,665.34	366.53
Employee Only	Family	Family	10,452.00	1,948.44	250.08	12,650.52	$9,127.00	3,523.52	352.35	8,214.30	4,436.22	443.62
Employee+1 Dependent	Emp	Emp	17,976.00	684.00	87.36	18,747.36	$15,020.00	3,727.36	372.74	13,518.00	5,229.36	522.94
Employee+1 Dependent	Emp+1	Emp+1	17,976.00	1,265.28	162.36	19,403.64	$15,020.00	4,383.64	438.36	13,518.00	5,885.64	588.56
Employee+1 Dependent	Family	Family	17,976.00	1,948.44	250.08	20,174.52	$15,020.00	5,154.52	515.45	13,518.00	6,656.52	665.65
Family Coverage	Emp	Emp	22,680.00	684.00	87.36	23,451.36	$19,127.00	4,324.36	432.44	17,214.30	6,237.06	623.71
Family Coverage	Emp+1	Emp+1	22,680.00	1,265.28	162.36	24,107.64	$19,127.00	4,980.64	498.06	17,214.30	6,893.34	689.33
Family Coverage	Family	Family	22,680.00	1,948.44	250.08	24,878.52	$19,127.00	5,751.52	575.15	17,214.30	7,664.22	766.42

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	3,921.76	392.18	6,845.25	4,378.11	437.81	5,476.20	5,747.16	574.72	4,563.50	6,659.86	665.99
Employee Only	Emp+1	Emp+1	7,301.60	4,578.04	457.80	6,845.25	5,034.39	503.44	5,476.20	6,403.44	640.34	4,563.50	7,316.14	731.61
Employee Only	Family	Family	7,301.60	5,348.92	534.89	6,845.25	5,805.27	580.53	5,476.20	7,174.32	717.43	4,563.50	8,087.02	808.70
Employee+1 Dependent	Emp	Emp	12,016.00	6,731.36	673.14	11,265.00	7,482.36	748.24	9,012.00	9,735.36	973.54	7,510.00	11,237.36	1,123.74
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	7,387.64	738.76	11,265.00	8,138.64	813.86	9,012.00	10,391.64	1,039.16	7,510.00	11,893.64	1,189.36
Employee+1 Dependent	Family	Family	12,016.00	8,158.52	815.85	11,265.00	8,909.52	890.95	9,012.00	11,162.52	1,116.25	7,510.00	12,664.52	1,266.45
Family Coverage	Emp	Emp	15,301.60	8,149.76	814.98	14,345.25	9,106.11	910.61	11,476.20	11,975.16	1,197.52	9,563.50	13,887.86	1,388.79
Family Coverage	Emp+1	Emp+1	15,301.60	8,806.04	880.60	14,345.25	9,762.39	976.24	11,476.20	12,631.44	1,263.14	9,563.50	14,544.14	1,454.41
Family Coverage	Family	Family	15,301.60	9,576.92	957.69	14,345.25	10,533.27	1,053.33	11,476.20	13,402.32	1,340.23	9,563.50	15,315.02	1,531.50

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

CVT Bronze Plan

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	5,940.00	684.00	87.36	6,711.36	$9,127.00	0.00	0.00	8,214.30	0.00	0.00
Employee Only	Emp+1	Emp+1	5,940.00	1,265.28	162.36	7,367.64	$9,127.00	0.00	0.00	8,214.30	0.00	0.00
Employee Only	Family	Family	5,940.00	1,948.44	250.08	8,138.52	$9,127.00	0.00	0.00	8,214.30	0.00	0.00
Employee+1 Dependent	Emp	Emp	10,212.00	684.00	87.36	10,983.36	$15,020.00	0.00	0.00	13,518.00	0.00	0.00
Employee+1 Dependent	Emp+1	Emp+1	10,212.00	1,265.28	162.36	11,639.64	$15,020.00	0.00	0.00	13,518.00	0.00	0.00
Employee+1 Dependent	Family	Family	10,212.00	1,948.44	250.08	12,410.52	$15,020.00	0.00	0.00	13,518.00	0.00	0.00
Family Coverage	Emp	Emp	12,888.00	684.00	87.36	13,659.36	$19,127.00	0.00	0.00	17,214.30	0.00	0.00
Family Coverage	Emp+1	Emp+1	12,888.00	1,265.28	162.36	14,315.64	$19,127.00	0.00	0.00	17,214.30	0.00	0.00
Family Coverage	Family	Family	12,888.00	1,948.44	250.08	15,086.52	$19,127.00	0.00	0.00	17,214.30	0.00	0.00

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	0.00	0.00	6,845.25	0.00	0.00	5,476.20	1,235.16	123.52	4,563.50	2,147.86	214.79
Employee Only	Emp+1	Emp+1	7,301.60	66.04	6.60	6,845.25	522.39	52.24	5,476.20	1,891.44	189.14	4,563.50	2,804.14	280.41
Employee Only	Family	Family	7,301.60	836.92	83.69	6,845.25	1,293.27	129.33	5,476.20	2,662.32	266.23	4,563.50	3,575.02	357.50
Employee+1 Dependent	Emp	Emp	12,016.00	0.00	0.00	11,265.00	0.00	0.00	9,012.00	1,971.36	197.14	7,510.00	3,473.36	347.34
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	0.00	0.00	11,265.00	374.64	37.46	9,012.00	2,627.64	262.76	7,510.00	4,129.64	412.96
Employee+1 Dependent	Family	Family	12,016.00	394.52	39.45	11,265.00	1,145.52	114.55	9,012.00	3,398.52	339.85	7,510.00	4,900.52	490.05
Family Coverage	Emp	Emp	15,301.60	0.00	0.00	14,345.25	0.00	0.00	11,476.20	2,183.16	218.32	9,563.50	4,095.86	409.59
Family Coverage	Emp+1	Emp+1	15,301.60	0.00	0.00	14,345.25	0.00	0.00	11,476.20	2,839.44	283.94	9,563.50	4,752.14	475.21
Family Coverage	Family	Family	15,301.60	0.00	0.00	14,345.25	741.27	74.13	11,476.20	3,610.32	361.03	9,563.50	5,523.02	552.30

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Anthem Blue Cross Wellness PPO Plan 1 RxC

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			THE COST OF PREMIUMS WILL BE:				1.0 FTE PAYROLL DEDUCTION			0.9 FTE PAYROLL DEDUCTION		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	10,692.00	684.00	87.36	11,463.36	$9,127.00	2,336.36	233.64	8,214.30	3,249.06	324.91
Employee Only	Emp+1	Emp+1	10,692.00	1,265.28	162.36	12,119.64	$9,127.00	2,992.64	299.26	8,214.30	3,905.34	390.53
Employee Only	Family	Family	10,692.00	1,948.44	250.08	12,890.52	$9,127.00	3,763.52	376.35	8,214.30	4,676.22	467.62
Employee+1 Dependent	Emp	Emp	18,384.00	684.00	87.36	19,155.36	$15,020.00	4,135.36	413.54	13,518.00	5,637.36	563.74
Employee+1 Dependent	Emp+1	Emp+1	18,384.00	1,265.28	162.36	19,811.64	$15,020.00	4,791.64	479.16	13,518.00	6,293.64	629.36
Employee+1 Dependent	Family	Family	18,384.00	1,948.44	250.08	20,582.52	$15,020.00	5,562.52	556.25	13,518.00	7,064.52	706.45
Family Coverage	Emp	Emp	23,208.00	684.00	87.36	23,979.36	$19,127.00	4,852.36	485.24	17,214.30	6,765.06	676.51
Family Coverage	Emp+1	Emp+1	23,208.00	1,265.28	162.36	24,635.64	$19,127.00	5,508.64	550.86	17,214.30	7,421.34	742.13
Family Coverage	Family	Family	23,208.00	1,948.44	250.08	25,406.52	$19,127.00	6,279.52	627.95	17,214.30	8,192.22	819.22

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			0.8 FTE PAYROLL DEDUCTION			0.75 FTE PAYROLL DEDUCTION			0.60 FTE PAYROLL DEDUCTION			0.50 FTE PAYROLL DEDUCTION		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	4,161.76	416.18	6,845.25	4,618.11	461.81	5,476.20	5,987.16	598.72	4,563.50	6,899.86	689.99
Employee Only	Emp+1	Emp+1	7,301.60	4,818.04	481.80	6,845.25	5,274.39	527.44	5,476.20	6,643.44	664.34	4,563.50	7,556.14	755.61
Employee Only	Family	Family	7,301.60	5,588.92	558.89	6,845.25	6,045.27	604.53	5,476.20	7,414.32	741.43	4,563.50	8,327.02	832.70
Employee+1 Dependent	Emp	Emp	12,016.00	7,139.36	713.94	11,265.00	7,890.36	789.04	9,012.00	10,143.36	1,014.34	7,510.00	11,645.36	1,164.54
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	7,795.64	779.56	11,265.00	8,546.64	854.66	9,012.00	10,799.64	1,079.96	7,510.00	12,301.64	1,230.16
Employee+1 Dependent	Family	Family	12,016.00	8,566.52	856.65	11,265.00	9,317.52	931.75	9,012.00	11,570.52	1,157.05	7,510.00	13,072.52	1,307.25
Family Coverage	Emp	Emp	15,301.60	8,677.76	867.78	14,345.25	9,634.11	963.41	11,476.20	12,503.16	1,250.32	9,563.50	14,415.86	1,441.59
Family Coverage	Emp+1	Emp+1	15,301.60	9,334.04	933.40	14,345.25	10,290.39	1,029.04	11,476.20	13,159.44	1,315.94	9,563.50	15,072.14	1,507.21
Family Coverage	Family	Family	15,301.60	10,104.92	1,010.49	14,345.25	11,061.27	1,106.13	11,476.20	13,930.32	1,393.03	9,563.50	15,843.02	1,584.30

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Anthem Blue Cross PPO HDHP 1 Rx H1

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	7,164.00	684.00	87.36	7,935.36	$9,127.00	0.00	0.00	8,214.30	0.00	0.00
Employee Only	Emp+1	Emp+1	7,164.00	1,265.28	162.36	8,591.64	$9,127.00	0.00	0.00	8,214.30	377.34	37.73
Employee Only	Family	Family	7,164.00	1,948.44	250.08	9,362.52	$9,127.00	235.52	23.55	8,214.30	1,148.22	114.82
Employee+1 Dependent	Emp	Emp	12,312.00	684.00	87.36	13,083.36	$15,020.00	0.00	0.00	13,518.00	0.00	0.00
Employee+1 Dependent	Emp+1	Emp+1	12,312.00	1,265.28	162.36	13,739.64	$15,020.00	0.00	0.00	13,518.00	221.64	22.16
Employee+1 Dependent	Family	Family	12,312.00	1,948.44	250.08	14,510.52	$15,020.00	0.00	0.00	13,518.00	992.52	99.25
Family Coverage	Emp	Emp	15,540.00	684.00	87.36	16,311.36	$19,127.00	0.00	0.00	17,214.30	0.00	0.00
Family Coverage	Emp+1	Emp+1	15,540.00	1,265.28	162.36	16,967.64	$19,127.00	0.00	0.00	17,214.30	0.00	0.00
Family Coverage	Family	Family	15,540.00	1,948.44	250.08	17,738.52	$19,127.00	0.00	0.00	17,214.30	524.22	52.42

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	633.76	63.38	6,845.25	1,090.11	109.01	5,476.20	2,459.16	245.92	4,563.50	3,371.86	337.19
Employee Only	Emp+1	Emp+1	7,301.60	1,290.04	129.00	6,845.25	1,746.39	174.64	5,476.20	3,115.44	311.54	4,563.50	4,028.14	402.81
Employee Only	Family	Family	7,301.60	2,060.92	206.09	6,845.25	2,517.27	251.73	5,476.20	3,886.32	388.63	4,563.50	4,799.02	479.90
Employee+1 Dependent	Emp	Emp	12,016.00	1,067.36	106.74	11,265.00	1,818.36	181.84	9,012.00	4,071.36	407.14	7,510.00	5,573.36	557.34
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	1,723.64	172.36	11,265.00	2,474.64	247.46	9,012.00	4,727.64	472.76	7,510.00	6,229.64	622.96
Employee+1 Dependent	Family	Family	12,016.00	2,494.52	249.45	11,265.00	3,245.52	324.55	9,012.00	5,498.52	549.85	7,510.00	7,000.52	700.05
Family Coverage	Emp	Emp	15,301.60	1,009.76	100.98	14,345.25	1,966.11	196.61	11,476.20	4,835.16	483.52	9,563.50	6,747.86	674.79
Family Coverage	Emp+1	Emp+1	15,301.60	1,666.04	166.60	14,345.25	2,622.39	262.24	11,476.20	5,491.44	549.14	9,563.50	7,404.14	740.41
Family Coverage	Family	Family	15,301.60	2,436.92	243.69	14,345.25	3,393.27	339.33	11,476.20	6,262.32	626.23	9,563.50	8,175.02	817.50

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Kaiser HMO Plan 1 (with Chiropractic and Vision Exam (without Lenses))

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	8,173.92	684.00	87.36	8,945.28	$9,127.00	0.00	0.00	8,214.30	730.98	73.10
Employee Only	Emp+1	Emp+1	8,173.92	1,265.28	162.36	9,601.56	$9,127.00	474.56	47.46	8,214.30	1,387.26	138.73
Employee Only	Family	Family	8,173.92	1,948.44	250.08	10,372.44	$9,127.00	1,245.44	124.54	8,214.30	2,158.14	215.81
Employee+1 Dependent	Emp	Emp	14,079.72	684.00	87.36	14,851.08	$15,020.00	0.00	0.00	13,518.00	1,333.08	133.31
Employee+1 Dependent	Emp+1	Emp+1	14,079.72	1,265.28	162.36	15,507.36	$15,020.00	487.36	48.74	13,518.00	1,989.36	198.94
Employee+1 Dependent	Family	Family	14,079.72	1,948.44	250.08	16,278.24	$15,020.00	1,258.24	125.82	13,518.00	2,760.24	276.02
Family Coverage	Emp	Emp	17,782.08	684.00	87.36	18,553.44	$19,127.00	0.00	0.00	17,214.30	1,339.14	133.91
Family Coverage	Emp+1	Emp+1	17,782.08	1,265.28	162.36	19,209.72	$19,127.00	82.72	8.27	17,214.30	1,995.42	199.54
Family Coverage	Family	Family	17,782.08	1,948.44	250.08	19,980.60	$19,127.00	853.60	85.36	17,214.30	2,766.30	276.63

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	1,643.68	164.37	6,845.25	2,100.03	210.00	5,476.20	3,469.08	346.91	4,563.50	4,381.78	438.18
Employee Only	Emp+1	Emp+1	7,301.60	2,299.96	230.00	6,845.25	2,756.31	275.63	5,476.20	4,125.36	412.54	4,563.50	5,038.06	503.81
Employee Only	Family	Family	7,301.60	3,070.84	307.08	6,845.25	3,527.19	352.72	5,476.20	4,896.24	489.62	4,563.50	5,808.94	580.89
Employee+1 Dependent	Emp	Emp	12,016.00	2,835.08	283.51	11,265.00	3,586.08	358.61	9,012.00	5,839.08	583.91	7,510.00	7,341.08	734.11
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	3,491.36	349.14	11,265.00	4,242.36	424.24	9,012.00	6,495.36	649.54	7,510.00	7,997.36	799.74
Employee+1 Dependent	Family	Family	12,016.00	4,262.24	426.22	11,265.00	5,013.24	501.32	9,012.00	7,266.24	726.62	7,510.00	8,768.24	876.82
Family Coverage	Emp	Emp	15,301.60	3,251.84	325.18	14,345.25	4,208.19	420.82	11,476.20	7,077.24	707.72	9,563.50	8,989.94	898.99
Family Coverage	Emp+1	Emp+1	15,301.60	3,908.12	390.81	14,345.25	4,864.47	486.45	11,476.20	7,733.52	773.35	9,563.50	9,646.22	964.62
Family Coverage	Family	Family	15,301.60	4,679.00	467.90	14,345.25	5,635.35	563.54	11,476.20	8,504.40	850.44	9,563.50	10,417.10	1,041.71

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Kaiser HMO Plan 2 (with Chiropractic and Vision Exam (without Lenses))

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	7,957.92	684.00	87.36	8,729.28	$9,127.00	0.00	0.00	8,214.30	514.98	51.50
Employee Only	Emp+1	Emp+1	7,957.92	1,265.28	162.36	9,385.56	$9,127.00	258.56	25.86	8,214.30	1,171.26	117.13
Employee Only	Family	Family	7,957.92	1,948.44	250.08	10,156.44	$9,127.00	1,029.44	102.94	8,214.30	1,942.14	194.21
Employee+1 Dependent	Emp	Emp	13,695.72	684.00	87.36	14,467.08	$15,020.00	0.00	0.00	13,518.00	949.08	94.91
Employee+1 Dependent	Emp+1	Emp+1	13,695.72	1,265.28	162.36	15,123.36	$15,020.00	103.36	10.34	13,518.00	1,605.36	160.54
Employee+1 Dependent	Family	Family	13,695.72	1,948.44	250.08	15,894.24	$15,020.00	874.24	87.42	13,518.00	2,376.24	237.62
Family Coverage	Emp	Emp	17,302.08	684.00	87.36	18,073.44	$19,127.00	0.00	0.00	17,214.30	859.14	85.91
Family Coverage	Emp+1	Emp+1	17,302.08	1,265.28	162.36	18,729.72	$19,127.00	0.00	0.00	17,214.30	1,515.42	151.54
Family Coverage	Family	Family	17,302.08	1,948.44	250.08	19,500.60	$19,127.00	373.60	37.36	17,214.30	2,286.30	228.63

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	1,427.68	142.77	6,845.25	1,884.03	188.40	5,476.20	3,253.08	325.31	4,563.50	4,165.78	416.58
Employee Only	Emp+1	Emp+1	7,301.60	2,083.96	208.40	6,845.25	2,540.31	254.03	5,476.20	3,909.36	390.94	4,563.50	4,822.06	482.21
Employee Only	Family	Family	7,301.60	2,854.84	285.48	6,845.25	3,311.19	331.12	5,476.20	4,680.24	468.02	4,563.50	5,592.94	559.29
Employee+1 Dependent	Emp	Emp	12,016.00	2,451.08	245.11	11,265.00	3,202.08	320.21	9,012.00	5,455.08	545.51	7,510.00	6,957.08	695.71
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	3,107.36	310.74	11,265.00	3,858.36	385.84	9,012.00	6,111.36	611.14	7,510.00	7,613.36	761.34
Employee+1 Dependent	Family	Family	12,016.00	3,878.24	387.82	11,265.00	4,629.24	462.92	9,012.00	6,882.24	688.22	7,510.00	8,384.24	838.42
Family Coverage	Emp	Emp	15,301.60	2,771.84	277.18	14,345.25	3,728.19	372.82	11,476.20	6,597.24	659.72	9,563.50	8,509.94	850.99
Family Coverage	Emp+1	Emp+1	15,301.60	3,428.12	342.81	14,345.25	4,384.47	438.45	11,476.20	7,253.52	725.35	9,563.50	9,166.22	916.62
Family Coverage	Family	Family	15,301.60	4,199.00	419.90	14,345.25	5,155.35	515.54	11,476.20	8,024.40	802.44	9,563.50	9,937.10	993.71

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.

CVT Benefits Plan

Kaiser HMO Plan 6 (with Chiropractic and Vision Exam (includes Lenses))

2021-22 Health Benefits Cap & Estimated Payroll Deductions for Full Time & Part-Time Administration, Certificated & Classified Employees

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*THE COST OF PREMIUMS WILL BE:*				*1.0 FTE PAYROLL DEDUCTION*			*0.9 FTE PAYROLL DEDUCTION*		
							District	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	**Medical**	**Dental**	**Vision**	**Total**	Cap (100%)	Annual	Monthly	Cap (90%)	Annual	Monthly
Employee Only	Emp	Emp	7,645.92	684.00	87.36	8,417.28	$9,127.00	0.00	0.00	8,214.30	202.98	20.30
Employee Only	Emp+1	Emp+1	7,645.92	1,265.28	162.36	9,073.56	$9,127.00	0.00	0.00	8,214.30	859.26	85.93
Employee Only	Family	Family	7,645.92	1,948.44	250.08	9,844.44	$9,127.00	717.44	71.74	8,214.30	1,630.14	163.01
Employee+1 Dependent	Emp	Emp	13,167.72	684.00	87.36	13,939.08	$15,020.00	0.00	0.00	13,518.00	421.08	42.11
Employee+1 Dependent	Emp+1	Emp+1	13,167.72	1,265.28	162.36	14,595.36	$15,020.00	0.00	0.00	13,518.00	1,077.36	107.74
Employee+1 Dependent	Family	Family	13,167.72	1,948.44	250.08	15,366.24	$15,020.00	346.24	34.62	13,518.00	1,848.24	184.82
Family Coverage	Emp	Emp	16,630.08	684.00	87.36	17,401.44	$19,127.00	0.00	0.00	17,214.30	187.14	18.71
Family Coverage	Emp+1	Emp+1	16,630.08	1,265.28	162.36	18,057.72	$19,127.00	0.00	0.00	17,214.30	843.42	84.34
Family Coverage	Family	Family	16,630.08	1,948.44	250.08	18,828.60	$19,127.00	0.00	0.00	17,214.30	1,614.30	161.43

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			*0.8 FTE PAYROLL DEDUCTION*			*0.75 FTE PAYROLL DEDUCTION*			*0.60 FTE PAYROLL DEDUCTION*			*0.50 FTE PAYROLL DEDUCTION*		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	7,301.60	1,115.68	111.57	6,845.25	1,572.03	157.20	5,476.20	2,941.08	294.11	4,563.50	3,853.78	385.38
Employee Only	Emp+1	Emp+1	7,301.60	1,771.96	177.20	6,845.25	2,228.31	222.83	5,476.20	3,597.36	359.74	4,563.50	4,510.06	451.01
Employee Only	Family	Family	7,301.60	2,542.84	254.28	6,845.25	2,999.19	299.92	5,476.20	4,368.24	436.82	4,563.50	5,280.94	528.09
Employee+1 Dependent	Emp	Emp	12,016.00	1,923.08	192.31	11,265.00	2,674.08	267.41	9,012.00	4,927.08	492.71	7,510.00	6,429.08	642.91
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	2,579.36	257.94	11,265.00	3,330.36	333.04	9,012.00	5,583.36	558.34	7,510.00	7,085.36	708.54
Employee+1 Dependent	Family	Family	12,016.00	3,350.24	335.02	11,265.00	4,101.24	410.12	9,012.00	6,354.24	635.42	7,510.00	7,856.24	785.62
Family Coverage	Emp	Emp	15,301.60	2,099.84	209.98	14,345.25	3,056.19	305.62	11,476.20	5,925.24	592.52	9,563.50	7,837.94	783.79
Family Coverage	Emp+1	Emp+1	15,301.60	2,756.12	275.61	14,345.25	3,712.47	371.25	11,476.20	6,581.52	658.15	9,563.50	8,494.22	849.42
Family Coverage	Family	Family	15,301.60	3,527.00	352.70	14,345.25	4,483.35	448.34	11,476.20	7,352.40	735.24	9,563.50	9,265.10	926.51

NOTES:

Benefits Cap: The District benefits cap allocation for 2021-22 is a three-tiered sliding cap. The cap is determined by the number of enrolled (the employee plus any dependents) in a medical plan (Blue Cross PPOs or Kaiser HMOs). The cap is $9,127 for employee-only medical coverage, $15,020 for employee plus one dependent, $19,127 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

Eligible Part-Time Employees: Eligible part-time employees are those who work 0.5 FTE or greater.