Business and Administrative Services

TO: New Employees
FROM: Linda Castellano, Administrative Assistant HR eMail lcastellano@opusd.org
DATE: July 15, 2024
SUBJECT: Insurance

HEALTH INSURANCE: New employees have 30 days to turn in information, and benefits begin the first day of the following month. If the new employee is full time, they must enroll in health, dental and vision plans; the default is lowest plan if they don't respond. If they are part time, they can "opt out". "Opt out" is the default if they do not respond within 30 days. Changes can be made if there is a "qualifying" event, or annually at open enrollment. See the District website for additional information on the available plans: https://www.oakparkusd.org/Page/4298. Employees are encouraged to setup their own accounts at https://mycvt.cvtrust.org. Information and plan selection can then be entered directly online.

Tax Deferred Solutions (TDS) – OPUSD uses a 3rd Party Administrator (TDS Group) to handle a variety of individual and group insurance plans for life, accident, hospital, and cancer, as well as Section 125 flexible spending accounts (FSAs) and tax sheltered annuities. Their benefit counselors are available at 1-800-863-9019. The information on available tax sheltered annuity programs can be found on the web at www.403bcompare.com.

VOLUNTARY GROUP LIFE INSURANCE: This insurance is available to all employees who are .5 FTE or greater. They must enroll within the first 30 days of employment. One exception: If employee goes from less than .5 FTE to greater than .5 FTE they can enroll within the first 30 days of the change in FTE without evidence of insurability. This insurance is through Cigna and can be payroll deducted. Forms may be obtained from the Business Office. An employee can get group insurance later – but must go through the entire underwriting process, which includes evidence of insurability. THERE IS NO OTHER QUALIFYING EVENT.

STANDARD INSURANCE: This insurance is the CTA authorized carrier. Teachers can get both Life Insurance and Disability Insurance through Standard Insurance and they should apply individually and directly with Standard. If a new teacher applies within the first 120 days, there is no health questionnaire. Teachers can call directly to their customer service at 800.522.0406 or email CTAQservice@standard.com. Deductions are made through the payroll system. In order for employees to enroll in the insurance, they must meet the following requirements:

1. Must be a dues-paying member of the CTA
2. Must have a contract with the school district
3. Must work an average of 15 hours/week or more

CTA has a Death & Dismemberment Plan and members have to sign up to name their beneficiary at http://www.cta.org. The death benefit is $2,000 and Accidental Death & Dismemberment of $10,000. NEA has NEA Complimentary Life Insurance at http://www.neamb.com. Again, members have to sign up to name their beneficiary for $1,000 and $5,000 for accidental death and dismemberment. Both are free but teachers need to sign up to name the beneficiary.

Please feel free to contact Linda Castellano in Human Resources or the Business Office for further information regarding your health benefits and other insurance.

Linda Castellano lcastellano@opusd.org

Open Enrollment

Effective Date: October 1, 2024

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 15, 2024
through
August 16, 2024

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

August 8, 2024
8:00 a.m. – 12:00 p.m.
https://calendly.com/elizabethp-3/oak-park-open-enrollment-2

August 15, 2024
1:00 p.m. – 5:00 p.m.
https://calendly.com/isabelp/oakparkopenenrollment

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
818-735-3220
lcastellano@opusd.org

CVT Contact:

Member Services Department

1-800-288-9870

California's Valued Trust
Healthcare Benefits for the Education Community

TDS ANNUAL FLEXIBLE BENEFITS
Open Enrollment for 2024

It is recommended that all employees call a Benefits Counselor each year to receive a briefing on their flexible spending account, dependent day care and other voluntary pre-tax options offered by the district. ***As an added service, you may also receive a call from a Benefits Counselor to explain plan options.*** **Employee enrollment in the plans is optional.**

Oak Park USD provides you with several benefit options where you can use pre-tax money to increase your spending power and protect you when unforeseen events put you at risk with loss of income, unanticipated medical expenses or worse.

Call 1-800-863-9019 for more information and enrollment.

Summary of Available Options

- ✓ Medical flexible spending account
- ✓ Dependent care flexible spending account
- ✓ Short-term disability
- ✓ Long-term disability
- ✓ Life insurance
- ✓ Cancer insurance
- ✓ Accident insurance
- ✓ Critical illness insurance

Open Enrollment Dates:

July 15, 2024 – August 16, 2024

BENEFITS BEGIN – October 1st.

Life and Long Term Care coverage is available as a single plan at a fixed rate for as long as the plan is in force. Schedule an appointment online here or
Call in **(1-800-863-9019)** today to learn more.

Enrollment is as easy as 1-2-3 and you're all set!

- Step #1: Call 1-800-863-9019 or schedule an appointment and speak with a Benefits Counselor to go over your options.
- Step #2: Make your selections with the Benefits Counselor.
- Step #3: The Benefits Counselor will handle your enrollment over the phone.

You must renew your election in medical & dependent care flexible spending accounts each year.

For information and enrollment call 1-800-863-9019 today!

Employee Support Center Business Hours:

Monday- Friday: 8:00am - 5:00pm.

Voluntary Term Life Insurance Coverage ~ *Paid by you*
Prepared for the Employees of Oak Park Unified School District

What would happen to your family if you and your income were gone?

- *Could they maintain their standard of living?*
- *Pay for college tuition?*
- *Household bills?*
- *What about monthly mortgage or rent?*

Three in 10 households carry no life insurance on anyone in the household.

Household Trends in U.S. Life Insurance Ownership. LIMRA, 2010

Half of U.S. households now believe they are underinsured.

Household Trends in U.S. Life Insurance Ownership. LIMRA,2010

Employee – All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week.

- Benefit Amount - Units of $10,000
- Guaranteed Coverage Amount - $120,00
- Maximum - $120,000
- Benefit Reduction Schedule - Providing you are still employed, your benefits will reduce to 65% at age 70, 45% at age 75.

Your Spouse – Up to age 70 is eligible provided that you apply for and are approved for coverage for yourself.

- Benefit Amount - Units of $5,000
- Guaranteed Coverage Amount - $50,000
- Maximum - $50,000, or 50% of the employee's coverage amount

Your Unmarried, Dependent Children - Birth to 6 months: $500
Under age 26, as long as you apply for and are approved for coverage for yourself·.

- Benefit Amount- Units of $2,000
- Maximum - $10,000

No one maybe covered more than once under this plan.

**For purposes of this brochure, wherever the term Spouse appears it shall also include Domestic Partner or Civil Union Partner. Your domestic partner is eligible for insurance if he or she meets specific criteria stated in the Group policy. Additional information is available from your Benefit Services Representative.*

Guaranteed Coverage for Voluntary Term Life Insurance Coverage

Guaranteed Coverage Amount is the amount of coverage you can elect without answering any medical questions or taking a health exam.

Guaranteed Coverage is only available during Initial Enrollment and other times as approved. If you apply for coverage that is above the

Guaranteed Coverage Amount, or if you are applying for coverage after 31 days after you become eligible, you must fill out a Medical Evidence of Insurability form. All dependent child benefits are guarantee issue.

Voluntary Term Life Insurance Overview – How Much Your Coverage Will Cost Per Month

Life Insurance					
		Vol EE	Vol SPS	Vol CHD	
Grandfathered Benefit		$ 360,000.00	$ 100,000.00		Basic
Max Standard Benefit		$ 120,000.00	$ 50,000.00	$ 10,000.00	Dependent
Rate Per		$ 1,000.00	$ 1,000.00	$ 1,000.00	PEPM
18	19	$ 0.068	$ 0.138	$ 0.10	
20	24	$ 0.068	$ 0.138		
25	29	$ 0.068	$ 0.138		
30	34	$ 0.079	$ 0.156		
35	39	$ 0.099	$ 0.190		
40	44	$ 0.157	$ 0.294		
45	49	$ 0.274	$ 0.502		
50	54	$ 0.464	$ 0.828		
55	59	$ 0.756	$ 1.296		
60	64	$ 0.985	$ 2.022		
65	69	$ 1.717	$ 3.536		
70	74	$ 2.975			
75	79	$ 2.975			
80	84	$ 9.193			
85	89	$ 9.193			
90	94	$ 9.193			
95	99	$ 9.193			

*Spouse Coverage ends at age 70

*Costs are subject to change

Cost Calculation Example

	Age	Monthly Cost per $1,000.00		Benefit				Monthly Cost
Example	33	0.079	X	100,000	÷	1,000	=	$ 7.90

Other Coverage Features

Accelerated Death Benefit–Terminal Illness If you or your spouse is diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the benefit for terminal Illness provides for up to 50% of the Voluntary Term Life Insurance coverage amount inforce or $60,000, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.

Continuation for Disability for Employees Age 60 or over

If your active service ends due to disability, at age 60 or over, your coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or· you are receiving disability benefits under your Employer's plan

Extended Death Benefit

The extended death benefit ensures that if you become disabled prior to age 60, and die before it is determined if you qualify for Waiver of Premium, we will pay the life insurance benefit if you remain disabled during that period. If you qualify for this benefit and have insured your spouse or children, their coverage is also extended. No additional premium payment is required for the extended coverage.

Cigna®

INSURANCE ENROLLMENT FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

EMPLOYER **Oak Park Unified School District**

Important: *Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink)*

EMPLOYEE SECTION

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ☐ M ☐ F

Important: You must complete an Evidence of Insurability Form if applying for life insurance.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

☐ I am currently married and my date of marriage is _____ *–or–* ☐ I currently have an eligible Domestic Partner

Spouse or Domestic Partner Information

Name (First) _____ (Last) _____ Social Security # _____

Birthdate _____ Sex: ☐ M ☐ F

TERM LIFE INSURANCE — POLICY NO. FLX 965974

	Applicant	***Decline***	***Requested Amount***	***Maximum Coverage Amount***
Voluntary Employee-Paid Coverage	Employee	☐	☐ Number of $10,000 units _____	$120,000
	Spouse/Domestic Partner	☐	☐ Number of $5,000 units _____	$50,000
	Child(ren)	☐	☐ Number of $2,000 units _____	$10,000

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate.

☞ Signature _____ Date _____

Please Sign Here

See next page for Beneficiary Designation
Return this form to your employer. Be sure to make a copy for your own records.

04/2014

Applicant's Name _____ **Social Security #** _____

BENEFICIARY

To ***specify a beneficiary***, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

TERM LIFE INSURANCE — POLICY NO. FLX 965974					
Insured	***Beneficiary***	***Percentage***	***Social Security #***	***Date of Birth***	***Relationship***
Employee					
Spouse/Domestic Partner					
Child(ren)					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Owner Signature _____ Date _____

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will, which was intended to create this trust, may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Return this form to your employer. Be sure to make a copy for your own records.

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

Helpful Phone Numbers and Website Addresses

October 1, 2024 – September 30, 2025

CVT Preferred Provider Organization (PPO) Plan with Anthem Blue Cross and CVS/caremark		
California's Valued Trust (CVT) Member Services	(800) 288-9870	www.cvtrust.org
Anthem Blue Cross Dedicated CVT Claims Unit	(800) 234-4333	www.anthem.com/ca/cvt
Anthem Global Core – Care outside the United States	(800) 810-2583	www.bluecares.com
CVS/caremark Prescription Drug Benefit (Active members and non-Medicare retirees)	(888) 354-6390	www.caremark.com
SilverScript Prescription Drug Benefit (Medicare retirees)	(888) 620-1756	www.silverscript.com
AccordantCare Health Management Program (Rare, complex conditions)	(800) 948-2497	www.accordant.com
MDLIVE – 24/7 non-emergency access to doctors, therapists and psychiatrists	(888) 632-2738	www.mdlive.com/cvt
TruHearing Select Discount Hearing Aid Program	(844) 300-0134	www.truhearing.com/select
Carelon Employee Assistance Program (EAP)	(877) 397-1032	www.achievesolutions.net/cvt
Solera4Me Diabetes Prevention Program	(877) 486-0141	www.solera4me.com/cvt
CVT Health Maintenance Organization (HMO) Plan with Kaiser Permanente		
Kaiser Permanente Member Services – Find a provider assistance, Change Provider, Pharmacy assistance	(800) 464-4000	www.kp.org
Additional Coverage Information		
Delta Dental of California	(866) 499-3001	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com

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

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

October 1, 2024 - September 30, 2025

BENEFIT	PPO 3, Rx B	PPO 5, Rx B	PPO 7, Rx B	PPO 10, Rx B
Calendar Year Deductible	Individual: $100 Family: $200	Individual: $100 Family: $200	Individual: $250 Family: $500	Individual: $2,000 Family: $4,000
Coinsurance	Paid at 100%* after deductible is met	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: $1,250(2) Family: $2,500(2)	Individual: $1,250(2) Family: $2,500(2)	Individual: $2,000(2) Family: $4,000(2)	Individual: $6,350(2) Family: $12,700(2)
Doctor Visits	**Primary Care Physician** - $20 Copay **Specialist Physician** - $20 Copay	**Primary Care Physician** - $30 Copay **Specialist Physician** - $30 Copay	**Primary Care Physician** - $30 Copay **Specialist Physician** - $30 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%* 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%*	**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%* 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%*	**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%* after deductible is met	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%* after deductible is met	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) 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.)	Paid at 80%*(1) after deductible is met (Copay, if applicable.)
Chiropractic	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.)	Paid at 80%*(1) after deductible is met (Copay, if applicable.)
Acupuncture	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	Paid at 80%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year
Outpatient Surgery	**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%*	**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%* 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	Paid at 80%* after deductible is met; Unlimited days, Semi-private room
Hospital Emergency Room	**$150 Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 100%*	**$150 Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 90%*	**$150 Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 80%*	**$150 Copay** (Copay waived if admitted as inpatient) After deductible is met, copay then paid at 80%*
Urgent Care	$20 Copay	$30 Copay	$30 Copay	Paid at 80%* after deductible is met
Home Health Care	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	Paid at 80%* after deductible is met; Limited to 100 visits per calendar year

BENEFIT	PPO 3, Rx B		PPO 5, Rx B		PPO 7, Rx B		PPO 10, Rx B	
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**	
Employee Assistance Program (EAP) through Carelon	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 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, 2024 - September 30, 2025

BENEFIT	Wellness, Rx C	HDHP 1	Bronze
Calendar Year Deductible	Individual: $500 Family: $1,000	Individual: $1,600 Family: $3,200 (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: $5,000 Family: $10,000 Family = Employee with 1 or more covered dependents. No one individual will pay more than $5,000.	Individual: $7,000 Family: $14,000
Doctor Visits	**Primary Care Physician** - $20 Copay **Specialist Physician** - $40 Copay	**Primary Care Physician** - Paid at 90%* after deductible is met **Specialist Physician** - 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 **Specialist Physician** - Subject to deductible then 70% 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 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	$150 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	Wellness, Rx C		HDHP 1		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 100%* after deductible is met for non-emergency medical, dermatology, and behavioral health consultations. Call **1-888-632-2738** or visit **www.mdlive.com/CVT**		MDLIVE - Paid at 100%* for non-emergency medical, dermatology and behavioral health consultations. Call **1-888-632-2738** or visit **www.mdlive.com/CVT**	
Employee Assistance Program (EAP) through Carelon	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)	**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)	**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 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, 2024 - September 30, 2025

BENEFIT	Kaiser 1 w/Chiro	Kaiser 2 w/Chiro	Kaiser 6 w/Chiro	Kaiser 8 w/Chiro
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)(2)	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 Physician** - $10 Copay **Specialist Physician** - $10 Copay	**Primary Care Physician** - $15 Copay **Specialist Physician** - $15 Copay	**Primary Care Physician** - $25 Copay **Specialist Physician** - $25 Copay	**Primary Care Physician** - $20 Copay **Specialist Physician** - $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	$50 Per Trip If Medically Necessary	$150 Per Trip If Medically Necessary No deductible
Physical Therapy	$10 Copay	$15 Copay	$25 Copay	$20 Copay No Deductible
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	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	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	Paid at 80%* after deductible is met
Hospital Inpatient	Paid at 100%*	Paid at 100%*	$250 Copay	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	$15 Copay	$25 Copay	$20 Copay
Home Health Care	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* (Limits)	Paid at 100%* No Deductible (Limits)

BENEFIT	Kaiser 1 w/Chiro		Kaiser 2 w/Chiro		Kaiser 6 w/Chiro		Kaiser 8 w/Chiro	
Telehealth	Approved telephone and virtual visits are paid at 100%. Contact your provider or call 1-888-576-6225 for after-hours advice.		Approved telephone and virtual visits are paid at 100%. Contact your provider or call 1-888-576-6225 for after-hours advice.		Approved telephone and virtual visits are paid at 100%. Contact your provider or call 1-888-576-6225 for after-hours advice.		Approved telephone and virtual visits are paid at 100%. Contact your provider or call 1-888-576-6225 for after-hours advice.	
Employee Assistance Program (EAP) through Carelon	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** $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)	**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)

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, 2024 to September 30, 2025

Benefits and Covered Services*	PPO Network **	Premier Network and Out of Network **
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	$2,400	$2,000
Diagnostic & Preventive (D&P) Services Note: D & P does not count towards calendar year maximum 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

With VSP and California's Valued Trust (Plan B $15 Copay), your health comes first.

VSP® Vision Care provides you personalized eye care at VSP network locations with low or no out-of-pocket costs.

vsp™ | California's Valued Trust
Healthcare Benefits for the Education Community

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 which provide offers from VSP and leading industry brands totaling more than $3,000 in savings.

Provider choices you want.

With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

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.

Premier Edge™ Promise

You now have access to the Premier Edge Promise, a worry-free eyewear guarantee. This protects you from the unexpected when you go to a Premier Edge location whether it's accidentally broken or damaged glasses, your prescription changes or if you don't love the glasses you chose. Visit **vsp.com/zerocopay** for details.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Enroll through your employer today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

2024-2025

Oak Park Unified School District

Provider Network:
VSP Signature
Frequency:
Exam every 12 months
Frame every 24 months
Lenses every 12 months

vsp | California's Valued Trust
Healthcare Benefits for the Education Community

BENEFIT	DESCRIPTION	PREMIERMAX COPAY WITH PREMIER EDGE PROVIDERS	COPAY WITH OTHER VSP NETWORK PROVIDERS
COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Every 12 months	**$0**	$15 for exam and glasses
RETINAL SCREENING	• Images of the inside of the eye, used to screen for potential signs of eye disease • Every 12 months	**$0**	Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam	$20 per exam
PRESCRIPTION GLASSES			
FRAME[+]	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $110 Walmart/Sam's Club/Costco frame allowance • Every 24 months	Combined with exam	Combined with exam
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Combined with exam	Combined with exam
LENS ENHANCEMENTS[+]	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements • Every 12 months	$0 $80 – $90 $120 – $160	$0 $80 – $90 $120 – $160
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Everyday savings on entertainment, health and wellness, travel, and more with VSP Simple Values.		

†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.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP 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. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks is a VSP-affiliated company.

CVT Benefits Plan

Anthem Blue Cross PPO Plan 3B

2024-25 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	14,964.00	649.80	87.36	15,701.16	$9,127.00	6,574.16	657.42	8,214.30	7,486.86	748.69
Employee Only	Emp+1	Emp+1	14,964.00	1,201.92	162.36	16,328.28	$9,127.00	7,201.28	720.13	8,214.30	8,113.98	811.40
Employee Only	Family	Family	14,964.00	1,851.00	250.08	17,065.08	$9,127.00	7,938.08	793.81	8,214.30	8,850.78	885.08
Employee+1 Dependent	Emp	Emp	25,740.00	649.80	87.36	26,477.16	$15,020.00	11,457.16	1,145.72	13,518.00	12,959.16	1,295.92
Employee+1 Dependent	Emp+1	Emp+1	25,740.00	1,201.92	162.36	27,104.28	$15,020.00	12,084.28	1,208.43	13,518.00	13,586.28	1,358.63
Employee+1 Dependent	Family	Family	25,740.00	1,851.00	250.08	27,841.08	$15,020.00	12,821.08	1,282.11	13,518.00	14,323.08	1,432.31
Family Coverage	Emp	Emp	32,460.00	649.80	87.36	33,197.16	$19,127.00	14,070.16	1,407.02	17,214.30	15,982.86	1,598.29
Family Coverage	Emp+1	Emp+1	32,460.00	1,201.92	162.36	33,824.28	$19,127.00	14,697.28	1,469.73	17,214.30	16,609.98	1,661.00
Family Coverage	Family	Family	32,460.00	1,851.00	250.08	34,561.08	$19,127.00	15,434.08	1,543.41	17,214.30	17,346.78	1,734.68

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	8,399.56	839.96	6,845.25	8,855.91	885.59	5,476.20	10,224.96	1,022.50	4,563.50	11,137.66	1,113.77
Employee Only	Emp+1	Emp+1	7,301.60	9,026.68	902.67	6,845.25	9,483.03	948.30	5,476.20	10,852.08	1,085.21	4,563.50	11,764.78	1,176.48
Employee Only	Family	Family	7,301.60	9,763.48	976.35	6,845.25	10,219.83	1,021.98	5,476.20	11,588.88	1,158.89	4,563.50	12,501.58	1,250.16
Employee+1 Dependent	Emp	Emp	12,016.00	14,461.16	1,446.12	11,265.00	15,212.16	1,521.22	9,012.00	17,465.16	1,746.52	7,510.00	18,967.16	1,896.72
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	15,088.28	1,508.83	11,265.00	15,839.28	1,583.93	9,012.00	18,092.28	1,809.23	7,510.00	19,594.28	1,959.43
Employee+1 Dependent	Family	Family	12,016.00	15,825.08	1,582.51	11,265.00	16,576.08	1,657.61	9,012.00	18,829.08	1,882.91	7,510.00	20,331.08	2,033.11
Family Coverage	Emp	Emp	15,301.60	17,895.56	1,789.56	14,345.25	18,851.91	1,885.19	11,476.20	21,720.96	2,172.10	9,563.50	23,633.66	2,363.37
Family Coverage	Emp+1	Emp+1	15,301.60	18,522.68	1,852.27	14,345.25	19,479.03	1,947.90	11,476.20	22,348.08	2,234.81	9,563.50	24,260.78	2,426.08
Family Coverage	Family	Family	15,301.60	19,259.48	1,925.95	14,345.25	20,215.83	2,021.58	11,476.20	23,084.88	2,308.49	9,563.50	24,997.58	2,499.76

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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

2024-25 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	14,232.00	649.80	87.36	14,969.16	$9,127.00	5,842.16	584.22	8,214.30	6,754.86	675.49
Employee Only	Emp+1	Emp+1	14,232.00	1,201.92	162.36	15,596.28	$9,127.00	6,469.28	646.93	8,214.30	7,381.98	738.20
Employee Only	Family	Family	14,232.00	1,851.00	250.08	16,333.08	$9,127.00	7,206.08	720.61	8,214.30	8,118.78	811.88
Employee+1 Dependent	Emp	Emp	24,468.00	649.80	87.36	25,205.16	$15,020.00	10,185.16	1,018.52	13,518.00	11,687.16	1,168.72
Employee+1 Dependent	Emp+1	Emp+1	24,468.00	1,201.92	162.36	25,832.28	$15,020.00	10,812.28	1,081.23	13,518.00	12,314.28	1,231.43
Employee+1 Dependent	Family	Family	24,468.00	1,851.00	250.08	26,569.08	$15,020.00	11,549.08	1,154.91	13,518.00	13,051.08	1,305.11
Family Coverage	Emp	Emp	30,864.00	649.80	87.36	31,601.16	$19,127.00	12,474.16	1,247.42	17,214.30	14,386.86	1,438.69
Family Coverage	Emp+1	Emp+1	30,864.00	1,201.92	162.36	32,228.28	$19,127.00	13,101.28	1,310.13	17,214.30	15,013.98	1,501.40
Family Coverage	Family	Family	30,864.00	1,851.00	250.08	32,965.08	$19,127.00	13,838.08	1,383.81	17,214.30	15,750.78	1,575.08

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	7,667.56	766.76	6,845.25	8,123.91	812.39	5,476.20	9,492.96	949.30	4,563.50	10,405.66	1,040.57
Employee Only	Emp+1	Emp+1	7,301.60	8,294.68	829.47	6,845.25	8,751.03	875.10	5,476.20	10,120.08	1,012.01	4,563.50	11,032.78	1,103.28
Employee Only	Family	Family	7,301.60	9,031.48	903.15	6,845.25	9,487.83	948.78	5,476.20	10,856.88	1,085.69	4,563.50	11,769.58	1,176.96
Employee+1 Dependent	Emp	Emp	12,016.00	13,189.16	1,318.92	11,265.00	13,940.16	1,394.02	9,012.00	16,193.16	1,619.32	7,510.00	17,695.16	1,769.52
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	13,816.28	1,381.63	11,265.00	14,567.28	1,456.73	9,012.00	16,820.28	1,682.03	7,510.00	18,322.28	1,832.23
Employee+1 Dependent	Family	Family	12,016.00	14,553.08	1,455.31	11,265.00	15,304.08	1,530.41	9,012.00	17,557.08	1,755.71	7,510.00	19,059.08	1,905.91
Family Coverage	Emp	Emp	15,301.60	16,299.56	1,629.96	14,345.25	17,255.91	1,725.59	11,476.20	20,124.96	2,012.50	9,563.50	22,037.66	2,203.77
Family Coverage	Emp+1	Emp+1	15,301.60	16,926.68	1,692.67	14,345.25	17,883.03	1,788.30	11,476.20	20,752.08	2,075.21	9,563.50	22,664.78	2,266.48
Family Coverage	Family	Family	15,301.60	17,663.48	1,766.35	14,345.25	18,619.83	1,861.98	11,476.20	21,488.88	2,148.89	9,563.50	23,401.58	2,340.16

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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

2024-25 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	13,116.00	649.80	87.36	13,853.16	$9,127.00	4,726.16	472.62	8,214.30	5,638.86	563.89
Employee Only	Emp+1	Emp+1	13,116.00	1,201.92	162.36	14,480.28	$9,127.00	5,353.28	535.33	8,214.30	6,265.98	626.60
Employee Only	Family	Family	13,116.00	1,851.00	250.08	15,217.08	$9,127.00	6,090.08	609.01	8,214.30	7,002.78	700.28
Employee+1 Dependent	Emp	Emp	22,560.00	649.80	87.36	23,297.16	$15,020.00	8,277.16	827.72	13,518.00	9,779.16	977.92
Employee+1 Dependent	Emp+1	Emp+1	22,560.00	1,201.92	162.36	23,924.28	$15,020.00	8,904.28	890.43	13,518.00	10,406.28	1,040.63
Employee+1 Dependent	Family	Family	22,560.00	1,851.00	250.08	24,661.08	$15,020.00	9,641.08	964.11	13,518.00	11,143.08	1,114.31
Family Coverage	Emp	Emp	28,452.00	649.80	87.36	29,189.16	$19,127.00	10,062.16	1,006.22	17,214.30	11,974.86	1,197.49
Family Coverage	Emp+1	Emp+1	28,452.00	1,201.92	162.36	29,816.28	$19,127.00	10,689.28	1,068.93	17,214.30	12,601.98	1,260.20
Family Coverage	Family	Family	28,452.00	1,851.00	250.08	30,553.08	$19,127.00	11,426.08	1,142.61	17,214.30	13,338.78	1,333.88

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	6,551.56	655.16	6,845.25	7,007.91	700.79	5,476.20	8,376.96	837.70	4,563.50	9,289.66	928.97
Employee Only	Emp+1	Emp+1	7,301.60	7,178.68	717.87	6,845.25	7,635.03	763.50	5,476.20	9,004.08	900.41	4,563.50	9,916.78	991.68
Employee Only	Family	Family	7,301.60	7,915.48	791.55	6,845.25	8,371.83	837.18	5,476.20	9,740.88	974.09	4,563.50	10,653.58	1,065.36
Employee+1 Dependent	Emp	Emp	12,016.00	11,281.16	1,128.12	11,265.00	12,032.16	1,203.22	9,012.00	14,285.16	1,428.52	7,510.00	15,787.16	1,578.72
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	11,908.28	1,190.83	11,265.00	12,659.28	1,265.93	9,012.00	14,912.28	1,491.23	7,510.00	16,414.28	1,641.43
Employee+1 Dependent	Family	Family	12,016.00	12,645.08	1,264.51	11,265.00	13,396.08	1,339.61	9,012.00	15,649.08	1,564.91	7,510.00	17,151.08	1,715.11
Family Coverage	Emp	Emp	15,301.60	13,887.56	1,388.76	14,345.25	14,843.91	1,484.39	11,476.20	17,712.96	1,771.30	9,563.50	19,625.66	1,962.57
Family Coverage	Emp+1	Emp+1	15,301.60	14,514.68	1,451.47	14,345.25	15,471.03	1,547.10	11,476.20	18,340.08	1,834.01	9,563.50	20,252.78	2,025.28
Family Coverage	Family	Family	15,301.60	15,251.48	1,525.15	14,345.25	16,207.83	1,620.78	11,476.20	19,076.88	1,907.69	9,563.50	20,989.58	2,098.96

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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 10B

2024-25 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	9,228.00	649.80	87.36	9,965.16	$9,127.00	838.16	83.82	8,214.30	1,750.86	175.09
Employee Only	Emp+1	Emp+1	9,228.00	1,201.92	162.36	10,592.28	$9,127.00	1,465.28	146.53	8,214.30	2,377.98	237.80
Employee Only	Family	Family	9,228.00	1,851.00	250.08	11,329.08	$9,127.00	2,202.08	220.21	8,214.30	3,114.78	311.48
Employee+1 Dependent	Emp	Emp	15,876.00	649.80	87.36	16,613.16	$15,020.00	1,593.16	159.32	13,518.00	3,095.16	309.52
Employee+1 Dependent	Emp+1	Emp+1	15,876.00	1,201.92	162.36	17,240.28	$15,020.00	2,220.28	222.03	13,518.00	3,722.28	372.23
Employee+1 Dependent	Family	Family	15,876.00	1,851.00	250.08	17,977.08	$15,020.00	2,957.08	295.71	13,518.00	4,459.08	445.91
Family Coverage	Emp	Emp	20,016.00	649.80	87.36	20,753.16	$19,127.00	1,626.16	162.62	17,214.30	3,538.86	353.89
Family Coverage	Emp+1	Emp+1	20,016.00	1,201.92	162.36	21,380.28	$19,127.00	2,253.28	225.33	17,214.30	4,165.98	416.60
Family Coverage	Family	Family	20,016.00	1,851.00	250.08	22,117.08	$19,127.00	2,990.08	299.01	17,214.30	4,902.78	490.28

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	2,663.56	266.36	6,845.25	3,119.91	311.99	5,476.20	4,488.96	448.90	4,563.50	5,401.66	540.17
Employee Only	Emp+1	Emp+1	7,301.60	3,290.68	329.07	6,845.25	3,747.03	374.70	5,476.20	5,116.08	511.61	4,563.50	6,028.78	602.88
Employee Only	Family	Family	7,301.60	4,027.48	402.75	6,845.25	4,483.83	448.38	5,476.20	5,852.88	585.29	4,563.50	6,765.58	676.56
Employee+1 Dependent	Emp	Emp	12,016.00	4,597.16	459.72	11,265.00	5,348.16	534.82	9,012.00	7,601.16	760.12	7,510.00	9,103.16	910.32
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	5,224.28	522.43	11,265.00	5,975.28	597.53	9,012.00	8,228.28	822.83	7,510.00	9,730.28	973.03
Employee+1 Dependent	Family	Family	12,016.00	5,961.08	596.11	11,265.00	6,712.08	671.21	9,012.00	8,965.08	896.51	7,510.00	10,467.08	1,046.71
Family Coverage	Emp	Emp	15,301.60	5,451.56	545.16	14,345.25	6,407.91	640.79	11,476.20	9,276.96	927.70	9,563.50	11,189.66	1,118.97
Family Coverage	Emp+1	Emp+1	15,301.60	6,078.68	607.87	14,345.25	7,035.03	703.50	11,476.20	9,904.08	990.41	9,563.50	11,816.78	1,181.68
Family Coverage	Family	Family	15,301.60	6,815.48	681.55	14,345.25	7,771.83	777.18	11,476.20	10,640.88	1,064.09	9,563.50	12,553.58	1,255.36

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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

2024-25 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	7,320.00	649.80	87.36	8,057.16	$9,127.00	0.00	0.00	8,214.30	0.00	0.00
Employee Only	Emp+1	Emp+1	7,320.00	1,201.92	162.36	8,684.28	$9,127.00	0.00	0.00	8,214.30	469.98	47.00
Employee Only	Family	Family	7,320.00	1,851.00	250.08	9,421.08	$9,127.00	294.08	29.41	8,214.30	1,206.78	120.68
Employee+1 Dependent	Emp	Emp	12,600.00	649.80	87.36	13,337.16	$15,020.00	0.00	0.00	13,518.00	0.00	0.00
Employee+1 Dependent	Emp+1	Emp+1	12,600.00	1,201.92	162.36	13,964.28	$15,020.00	0.00	0.00	13,518.00	446.28	44.63
Employee+1 Dependent	Family	Family	12,600.00	1,851.00	250.08	14,701.08	$15,020.00	0.00	0.00	13,518.00	1,183.08	118.31
Family Coverage	Emp	Emp	15,900.00	649.80	87.36	16,637.16	$19,127.00	0.00	0.00	17,214.30	0.00	0.00
Family Coverage	Emp+1	Emp+1	15,900.00	1,201.92	162.36	17,264.28	$19,127.00	0.00	0.00	17,214.30	49.98	5.00
Family Coverage	Family	Family	15,900.00	1,851.00	250.08	18,001.08	$19,127.00	0.00	0.00	17,214.30	786.78	78.68

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	755.56	75.56	6,845.25	1,211.91	121.19	5,476.20	2,580.96	258.10	4,563.50	3,493.66	349.37
Employee Only	Emp+1	Emp+1	7,301.60	1,382.68	138.27	6,845.25	1,839.03	183.90	5,476.20	3,208.08	320.81	4,563.50	4,120.78	412.08
Employee Only	Family	Family	7,301.60	2,119.48	211.95	6,845.25	2,575.83	257.58	5,476.20	3,944.88	394.49	4,563.50	4,857.58	485.76
Employee+1 Dependent	Emp	Emp	12,016.00	1,321.16	132.12	11,265.00	2,072.16	207.22	9,012.00	4,325.16	432.52	7,510.00	5,827.16	582.72
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	1,948.28	194.83	11,265.00	2,699.28	269.93	9,012.00	4,952.28	495.23	7,510.00	6,454.28	645.43
Employee+1 Dependent	Family	Family	12,016.00	2,685.08	268.51	11,265.00	3,436.08	343.61	9,012.00	5,689.08	568.91	7,510.00	7,191.08	719.11
Family Coverage	Emp	Emp	15,301.60	1,335.56	133.56	14,345.25	2,291.91	229.19	11,476.20	5,160.96	516.10	9,563.50	7,073.66	707.37
Family Coverage	Emp+1	Emp+1	15,301.60	1,962.68	196.27	14,345.25	2,919.03	291.90	11,476.20	5,788.08	578.81	9,563.50	7,700.78	770.08
Family Coverage	Family	Family	15,301.60	2,699.48	269.95	14,345.25	3,655.83	365.58	11,476.20	6,524.88	652.49	9,563.50	8,437.58	843.76

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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

2024-25 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	13,404.00	649.80	87.36	14,141.16	$9,127.00	5,014.16	501.42	8,214.30	5,926.86	592.69
Employee Only	Emp+1	Emp+1	13,404.00	1,201.92	162.36	14,768.28	$9,127.00	5,641.28	564.13	8,214.30	6,553.98	655.40
Employee Only	Family	Family	13,404.00	1,851.00	250.08	15,505.08	$9,127.00	6,378.08	637.81	8,214.30	7,290.78	729.08
Employee+1 Dependent	Emp	Emp	23,052.00	649.80	87.36	23,789.16	$15,020.00	8,769.16	876.92	13,518.00	10,271.16	1,027.12
Employee+1 Dependent	Emp+1	Emp+1	23,052.00	1,201.92	162.36	24,416.28	$15,020.00	9,396.28	939.63	13,518.00	10,898.28	1,089.83
Employee+1 Dependent	Family	Family	23,052.00	1,851.00	250.08	25,153.08	$15,020.00	10,133.08	1,013.31	13,518.00	11,635.08	1,163.51
Family Coverage	Emp	Emp	29,100.00	649.80	87.36	29,837.16	$19,127.00	10,710.16	1,071.02	17,214.30	12,622.86	1,262.29
Family Coverage	Emp+1	Emp+1	29,100.00	1,201.92	162.36	30,464.28	$19,127.00	11,337.28	1,133.73	17,214.30	13,249.98	1,325.00
Family Coverage	Family	Family	29,100.00	1,851.00	250.08	31,201.08	$19,127.00	12,074.08	1,207.41	17,214.30	13,986.78	1,398.68

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	6,839.56	683.96	6,845.25	7,295.91	729.59	5,476.20	8,664.96	866.50	4,563.50	9,577.66	957.77
Employee Only	Emp+1	Emp+1	7,301.60	7,466.68	746.67	6,845.25	7,923.03	792.30	5,476.20	9,292.08	929.21	4,563.50	10,204.78	1,020.48
Employee Only	Family	Family	7,301.60	8,203.48	820.35	6,845.25	8,659.83	865.98	5,476.20	10,028.88	1,002.89	4,563.50	10,941.58	1,094.16
Employee+1 Dependent	Emp	Emp	12,016.00	11,773.16	1,177.32	11,265.00	12,524.16	1,252.42	9,012.00	14,777.16	1,477.72	7,510.00	16,279.16	1,627.92
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	12,400.28	1,240.03	11,265.00	13,151.28	1,315.13	9,012.00	15,404.28	1,540.43	7,510.00	16,906.28	1,690.63
Employee+1 Dependent	Family	Family	12,016.00	13,137.08	1,313.71	11,265.00	13,888.08	1,388.81	9,012.00	16,141.08	1,614.11	7,510.00	17,643.08	1,764.31
Family Coverage	Emp	Emp	15,301.60	14,535.56	1,453.56	14,345.25	15,491.91	1,549.19	11,476.20	18,360.96	1,836.10	9,563.50	20,273.66	2,027.37
Family Coverage	Emp+1	Emp+1	15,301.60	15,162.68	1,516.27	14,345.25	16,119.03	1,611.90	11,476.20	18,988.08	1,898.81	9,563.50	20,900.78	2,090.08
Family Coverage	Family	Family	15,301.60	15,899.48	1,589.95	14,345.25	16,855.83	1,685.58	11,476.20	19,724.88	1,972.49	9,563.50	21,637.58	2,163.76

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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

2024-25 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	8,988.00	649.80	87.36	9,725.16	$9,127.00	598.16	59.82	8,214.30	1,510.86	151.09
Employee Only	Emp+1	Emp+1	8,988.00	1,201.92	162.36	10,352.28	$9,127.00	1,225.28	122.53	8,214.30	2,137.98	213.80
Employee Only	Family	Family	8,988.00	1,851.00	250.08	11,089.08	$9,127.00	1,962.08	196.21	8,214.30	2,874.78	287.48
Employee+1 Dependent	Emp	Emp	15,468.00	649.80	87.36	16,205.16	$15,020.00	1,185.16	118.52	13,518.00	2,687.16	268.72
Employee+1 Dependent	Emp+1	Emp+1	15,468.00	1,201.92	162.36	16,832.28	$15,020.00	1,812.28	181.23	13,518.00	3,314.28	331.43
Employee+1 Dependent	Family	Family	15,468.00	1,851.00	250.08	17,569.08	$15,020.00	2,549.08	254.91	13,518.00	4,051.08	405.11
Family Coverage	Emp	Emp	19,512.00	649.80	87.36	20,249.16	$19,127.00	1,122.16	112.22	17,214.30	3,034.86	303.49
Family Coverage	Emp+1	Emp+1	19,512.00	1,201.92	162.36	20,876.28	$19,127.00	1,749.28	174.93	17,214.30	3,661.98	366.20
Family Coverage	Family	Family	19,512.00	1,851.00	250.08	21,613.08	$19,127.00	2,486.08	248.61	17,214.30	4,398.78	439.88

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	2,423.56	242.36	6,845.25	2,879.91	287.99	5,476.20	4,248.96	424.90	4,563.50	5,161.66	516.17
Employee Only	Emp+1	Emp+1	7,301.60	3,050.68	305.07	6,845.25	3,507.03	350.70	5,476.20	4,876.08	487.61	4,563.50	5,788.78	578.88
Employee Only	Family	Family	7,301.60	3,787.48	378.75	6,845.25	4,243.83	424.38	5,476.20	5,612.88	561.29	4,563.50	6,525.58	652.56
Employee+1 Dependent	Emp	Emp	12,016.00	4,189.16	418.92	11,265.00	4,940.16	494.02	9,012.00	7,193.16	719.32	7,510.00	8,695.16	869.52
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	4,816.28	481.63	11,265.00	5,567.28	556.73	9,012.00	7,820.28	782.03	7,510.00	9,322.28	932.23
Employee+1 Dependent	Family	Family	12,016.00	5,553.08	555.31	11,265.00	6,304.08	630.41	9,012.00	8,557.08	855.71	7,510.00	10,059.08	1,005.91
Family Coverage	Emp	Emp	15,301.60	4,947.56	494.76	14,345.25	5,903.91	590.39	11,476.20	8,772.96	877.30	9,563.50	10,685.66	1,068.57
Family Coverage	Emp+1	Emp+1	15,301.60	5,574.68	557.47	14,345.25	6,531.03	653.10	11,476.20	9,400.08	940.01	9,563.50	11,312.78	1,131.28
Family Coverage	Family	Family	15,301.60	6,311.48	631.15	14,345.25	7,267.83	726.78	11,476.20	10,136.88	1,013.69	9,563.50	12,049.58	1,204.96

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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))

2024-25 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	10,213.92	649.80	87.36	10,951.08	$9,127.00	1,824.08	182.41	8,214.30	2,736.78	273.68
Employee Only	Emp+1	Emp+1	10,213.92	1,201.92	162.36	11,578.20	$9,127.00	2,451.20	245.12	8,214.30	3,363.90	336.39
Employee Only	Family	Family	10,213.92	1,851.00	250.08	12,315.00	$9,127.00	3,188.00	318.80	8,214.30	4,100.70	410.07
Employee+1 Dependent	Emp	Emp	17,571.72	649.80	87.36	18,308.88	$15,020.00	3,288.88	328.89	13,518.00	4,790.88	479.09
Employee+1 Dependent	Emp+1	Emp+1	17,571.72	1,201.92	162.36	18,936.00	$15,020.00	3,916.00	391.60	13,518.00	5,418.00	541.80
Employee+1 Dependent	Family	Family	17,571.72	1,851.00	250.08	19,672.80	$15,020.00	4,652.80	465.28	13,518.00	6,154.80	615.48
Family Coverage	Emp	Emp	22,198.08	649.80	87.36	22,935.24	$19,127.00	3,808.24	380.82	17,214.30	5,720.94	572.09
Family Coverage	Emp+1	Emp+1	22,198.08	1,201.92	162.36	23,562.36	$19,127.00	4,435.36	443.54	17,214.30	6,348.06	634.81
Family Coverage	Family	Family	22,198.08	1,851.00	250.08	24,299.16	$19,127.00	5,172.16	517.22	17,214.30	7,084.86	708.49

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	3,649.48	364.95	6,845.25	4,105.83	410.58	5,476.20	5,474.88	547.49	4,563.50	6,387.58	638.76
Employee Only	Emp+1	Emp+1	7,301.60	4,276.60	427.66	6,845.25	4,732.95	473.30	5,476.20	6,102.00	610.20	4,563.50	7,014.70	701.47
Employee Only	Family	Family	7,301.60	5,013.40	501.34	6,845.25	5,469.75	546.98	5,476.20	6,838.80	683.88	4,563.50	7,751.50	775.15
Employee+1 Dependent	Emp	Emp	12,016.00	6,292.88	629.29	11,265.00	7,043.88	704.39	9,012.00	9,296.88	929.69	7,510.00	10,798.88	1,079.89
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	6,920.00	692.00	11,265.00	7,671.00	767.10	9,012.00	9,924.00	992.40	7,510.00	11,426.00	1,142.60
Employee+1 Dependent	Family	Family	12,016.00	7,656.80	765.68	11,265.00	8,407.80	840.78	9,012.00	10,660.80	1,066.08	7,510.00	12,162.80	1,216.28
Family Coverage	Emp	Emp	15,301.60	7,633.64	763.36	14,345.25	8,589.99	859.00	11,476.20	11,459.04	1,145.90	9,563.50	13,371.74	1,337.17
Family Coverage	Emp+1	Emp+1	15,301.60	8,260.76	826.08	14,345.25	9,217.11	921.71	11,476.20	12,086.16	1,208.62	9,563.50	13,998.86	1,399.89
Family Coverage	Family	Family	15,301.60	8,997.56	899.76	14,345.25	9,953.91	995.39	11,476.20	12,822.96	1,282.30	9,563.50	14,735.66	1,473.57

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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))

2024-25 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	9,937.92	649.80	87.36	10,675.08	$9,127.00	1,548.08	154.81	8,214.30	2,460.78	246.08
Employee Only	Emp+1	Emp+1	9,937.92	1,201.92	162.36	11,302.20	$9,127.00	2,175.20	217.52	8,214.30	3,087.90	308.79
Employee Only	Family	Family	9,937.92	1,851.00	250.08	12,039.00	$9,127.00	2,912.00	291.20	8,214.30	3,824.70	382.47
Employee+1 Dependent	Emp	Emp	17,091.72	649.80	87.36	17,828.88	$15,020.00	2,808.88	280.89	13,518.00	4,310.88	431.09
Employee+1 Dependent	Emp+1	Emp+1	17,091.72	1,201.92	162.36	18,456.00	$15,020.00	3,436.00	343.60	13,518.00	4,938.00	493.80
Employee+1 Dependent	Family	Family	17,091.72	1,851.00	250.08	19,192.80	$15,020.00	4,172.80	417.28	13,518.00	5,674.80	567.48
Family Coverage	Emp	Emp	21,586.08	649.80	87.36	22,323.24	$19,127.00	3,196.24	319.62	17,214.30	5,108.94	510.89
Family Coverage	Emp+1	Emp+1	21,586.08	1,201.92	162.36	22,950.36	$19,127.00	3,823.36	382.34	17,214.30	5,736.06	573.61
Family Coverage	Family	Family	21,586.08	1,851.00	250.08	23,687.16	$19,127.00	4,560.16	456.02	17,214.30	6,472.86	647.29

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	3,373.48	337.35	6,845.25	3,829.83	382.98	5,476.20	5,198.88	519.89	4,563.50	6,111.58	611.16
Employee Only	Emp+1	Emp+1	7,301.60	4,000.60	400.06	6,845.25	4,456.95	445.70	5,476.20	5,826.00	582.60	4,563.50	6,738.70	673.87
Employee Only	Family	Family	7,301.60	4,737.40	473.74	6,845.25	5,193.75	519.38	5,476.20	6,562.80	656.28	4,563.50	7,475.50	747.55
Employee+1 Dependent	Emp	Emp	12,016.00	5,812.88	581.29	11,265.00	6,563.88	656.39	9,012.00	8,816.88	881.69	7,510.00	10,318.88	1,031.89
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	6,440.00	644.00	11,265.00	7,191.00	719.10	9,012.00	9,444.00	944.40	7,510.00	10,946.00	1,094.60
Employee+1 Dependent	Family	Family	12,016.00	7,176.80	717.68	11,265.00	7,927.80	792.78	9,012.00	10,180.80	1,018.08	7,510.00	11,682.80	1,168.28
Family Coverage	Emp	Emp	15,301.60	7,021.64	702.16	14,345.25	7,977.99	797.80	11,476.20	10,847.04	1,084.70	9,563.50	12,759.74	1,275.97
Family Coverage	Emp+1	Emp+1	15,301.60	7,648.76	764.88	14,345.25	8,605.11	860.51	11,476.20	11,474.16	1,147.42	9,563.50	13,386.86	1,338.69
Family Coverage	Family	Family	15,301.60	8,385.56	838.56	14,345.25	9,341.91	934.19	11,476.20	12,210.96	1,221.10	9,563.50	14,123.66	1,412.37

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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))

2024-25 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	9,553.92	649.80	87.36	10,291.08	$9,127.00	1,164.08	116.41	8,214.30	2,076.78	207.68
Employee Only	Emp+1	Emp+1	9,553.92	1,201.92	162.36	10,918.20	$9,127.00	1,791.20	179.12	8,214.30	2,703.90	270.39
Employee Only	Family	Family	9,553.92	1,851.00	250.08	11,655.00	$9,127.00	2,528.00	252.80	8,214.30	3,440.70	344.07
Employee+1 Dependent	Emp	Emp	16,431.72	649.80	87.36	17,168.88	$15,020.00	2,148.88	214.89	13,518.00	3,650.88	365.09
Employee+1 Dependent	Emp+1	Emp+1	16,431.72	1,201.92	162.36	17,796.00	$15,020.00	2,776.00	277.60	13,518.00	4,278.00	427.80
Employee+1 Dependent	Family	Family	16,431.72	1,851.00	250.08	18,532.80	$15,020.00	3,512.80	351.28	13,518.00	5,014.80	501.48
Family Coverage	Emp	Emp	20,746.08	649.80	87.36	21,483.24	$19,127.00	2,356.24	235.62	17,214.30	4,268.94	426.89
Family Coverage	Emp+1	Emp+1	20,746.08	1,201.92	162.36	22,110.36	$19,127.00	2,983.36	298.34	17,214.30	4,896.06	489.61
Family Coverage	Family	Family	20,746.08	1,851.00	250.08	22,847.16	$19,127.00	3,720.16	372.02	17,214.30	5,632.86	563.29

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	2,989.48	298.95	6,845.25	3,445.83	344.58	5,476.20	4,814.88	481.49	4,563.50	5,727.58	572.76
Employee Only	Emp+1	Emp+1	7,301.60	3,616.60	361.66	6,845.25	4,072.95	407.30	5,476.20	5,442.00	544.20	4,563.50	6,354.70	635.47
Employee Only	Family	Family	7,301.60	4,353.40	435.34	6,845.25	4,809.75	480.98	5,476.20	6,178.80	617.88	4,563.50	7,091.50	709.15
Employee+1 Dependent	Emp	Emp	12,016.00	5,152.88	515.29	11,265.00	5,903.88	590.39	9,012.00	8,156.88	815.69	7,510.00	9,658.88	965.89
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	5,780.00	578.00	11,265.00	6,531.00	653.10	9,012.00	8,784.00	878.40	7,510.00	10,286.00	1,028.60
Employee+1 Dependent	Family	Family	12,016.00	6,516.80	651.68	11,265.00	7,267.80	726.78	9,012.00	9,520.80	952.08	7,510.00	11,022.80	1,102.28
Family Coverage	Emp	Emp	15,301.60	6,181.64	618.16	14,345.25	7,137.99	713.80	11,476.20	10,007.04	1,000.70	9,563.50	11,919.74	1,191.97
Family Coverage	Emp+1	Emp+1	15,301.60	6,808.76	680.88	14,345.25	7,765.11	776.51	11,476.20	10,634.16	1,063.42	9,563.50	12,546.86	1,254.69
Family Coverage	Family	Family	15,301.60	7,545.56	754.56	14,345.25	8,501.91	850.19	11,476.20	11,370.96	1,137.10	9,563.50	13,283.66	1,328.37

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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 Deductible Plan 8 (with Chiropractic and Vision Exam (without Lenses))

2024-25 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	8,065.92	649.80	87.36	8,803.08	$9,127.00	0.00	0.00	8,214.30	588.78	58.88
Employee Only	Emp+1	Emp+1	8,065.92	1,201.92	162.36	9,430.20	$9,127.00	303.20	30.32	8,214.30	1,215.90	121.59
Employee Only	Family	Family	8,065.92	1,851.00	250.08	10,167.00	$9,127.00	1,040.00	104.00	8,214.30	1,952.70	195.27
Employee+1 Dependent	Emp	Emp	13,875.72	649.80	87.36	14,612.88	$15,020.00	0.00	0.00	13,518.00	1,094.88	109.49
Employee+1 Dependent	Emp+1	Emp+1	13,875.72	1,201.92	162.36	15,240.00	$15,020.00	220.00	22.00	13,518.00	1,722.00	172.20
Employee+1 Dependent	Family	Family	13,875.72	1,851.00	250.08	15,976.80	$15,020.00	956.80	95.68	13,518.00	2,458.80	245.88
Family Coverage	Emp	Emp	17,518.08	649.80	87.36	18,255.24	$19,127.00	0.00	0.00	17,214.30	1,040.94	104.09
Family Coverage	Emp+1	Emp+1	17,518.08	1,201.92	162.36	18,882.36	$19,127.00	0.00	0.00	17,214.30	1,668.06	166.81
Family Coverage	Family	Family	17,518.08	1,851.00	250.08	19,619.16	$19,127.00	492.16	49.22	17,214.30	2,404.86	240.49

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	1,501.48	150.15	6,845.25	1,957.83	195.78	5,476.20	3,326.88	332.69	4,563.50	4,239.58	423.96
Employee Only	Emp+1	Emp+1	7,301.60	2,128.60	212.86	6,845.25	2,584.95	258.50	5,476.20	3,954.00	395.40	4,563.50	4,866.70	486.67
Employee Only	Family	Family	7,301.60	2,865.40	286.54	6,845.25	3,321.75	332.18	5,476.20	4,690.80	469.08	4,563.50	5,603.50	560.35
Employee+1 Dependent	Emp	Emp	12,016.00	2,596.88	259.69	11,265.00	3,347.88	334.79	9,012.00	5,600.88	560.09	7,510.00	7,102.88	710.29
Employee+1 Dependent	Emp+1	Emp+1	12,016.00	3,224.00	322.40	11,265.00	3,975.00	397.50	9,012.00	6,228.00	622.80	7,510.00	7,730.00	773.00
Employee+1 Dependent	Family	Family	12,016.00	3,960.80	396.08	11,265.00	4,711.80	471.18	9,012.00	6,964.80	696.48	7,510.00	8,466.80	846.68
Family Coverage	Emp	Emp	15,301.60	2,953.64	295.36	14,345.25	3,909.99	391.00	11,476.20	6,779.04	677.90	9,563.50	8,691.74	869.17
Family Coverage	Emp+1	Emp+1	15,301.60	3,580.76	358.08	14,345.25	4,537.11	453.71	11,476.20	7,406.16	740.62	9,563.50	9,318.86	931.89
Family Coverage	Family	Family	15,301.60	4,317.56	431.76	14,345.25	5,273.91	527.39	11,476.20	8,142.96	814.30	9,563.50	10,055.66	1,005.57

NOTES:

Benefits Cap: The District benefits cap allocation for 2024-25 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.

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