TO: **MEMBERS, BOARD OF EDUCATION** **AMENDED**

FROM: **DR. ANTHONY W. KNIGHT, SUPERINTENDENT**

DATE: **JUNE 16, 2015**

SUBJECT: **B.2.f. APPROVE 2015-16 EMPLOYEE HEALTH BENEFIT PLANS**

ACTION

ISSUE: Shall the Board accept the recommendation of the District's Health Benefit Committee for renewal of 2015-16 employee medical, dental, and vision insurance coverage with California's Valued Trust?

BACKGROUND: At the end of May, the District's current health care provider, California's Valued Trust (CVT) announced its rates for the 2015-16 plan year. The District's current coverage offers a choice of nine medical plans, including seven Anthem Blue Cross PPO plans and three Kaiser plans, as well as Delta Dental and VSP Vision plans. The new rates include average increases of 7.8% for Blue Cross PPO plans. There is no increase in rates for Kaiser HMO plans or for Delta Dental coverage, and rates for the VSP vision plan decrease by 3.9%. The Health Benefits Committee, comprised of two employees each from OPTA, OPCA, and District administration, unanimously recommends the Board authorize the renewal of employee medical, vision and dental plans with CVT for the 2015-16 school year. Copies of the proposed renewal and rationale for the rate increase are included for the Board's information.

ALTERNATIVES:

1. Accept the Health Benefits Committee recommendation and approve contracts with California's Valued Trust for the 2015-16 school year.
2. Do not accept the Health Benefits Committee recommendation.

RECOMMENDATION: Alternative No. 1.

Prepared by: Martin Klauss, Assistant Superintendent, Business and Administrative Services

Respectfully submitted:

_____
Anthony W. Knight, Ed.D.
Superintendent

Board Action: On motion of _____, seconded by _____, the Board of Education:

VOTE:	AYES	NOES	ABSTAIN	ABSENT
Hazelton				
Helfstein				
Laifman				
Rosen				
Ross				
Student Rep				

2015 -2016 Rates

More choices, more options for your District and Members

CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

May 18, 2015

Dear CVT Member Districts and Chapter Leadership:

Enclosed is your 2015-2016 rate renewal information about your benefits and rates effective October 1, 2015.

Some factors influencing the cost of healthcare are stabilizing. Others, including the high cost of unexpected claims and the growing use of specialty drugs impact the rates CVT needs to charge to ensure coverage for all covered expenses. Rising pharmacy costs is not a condition unique to CVT. Nearly all healthcare benefit providers are experiencing the same nationally. We regularly monitor trend and implement programs that mitigate the impact as much as possible.

CVT continues to develop programs to help members take an active role in their healthcare and improve the overall health of our members through various initiatives such as wellness plans, health management programs, Fit for Life wellness program and our EAP program, to name a few. We provide members with MDLIVE, 24/7 access to U.S. board-certified doctors by phone or the Internet for non-emergent care. At CVT, our goal is to keep costs manageable and as affordable as possible for all members while helping members stay healthy.

We are also mindful of your role in sharing CVT information and programs with members, and helping them with their benefit options. We sincerely appreciate your assistance. The CVT team looks forward to working with you in the coming year. Our goal is to remain the best choice for districts and chapters by providing high-quality cost-effective benefit choices and responsive customer service.

We thank you for the opportunity to provide your benefits. If you have any questions please feel free to contact your Account Manager.

Sincerely,

Valerie Cornuelle

Valerie Cornuelle
Executive Director

Table of Contents

California's Valued Trust (CVT) has adopted the following rate and benefit changes effective October 1, 2015 for Districts/Units with Anthem Blue Cross PPO Plans paired with CVS/caremark Pharmacy Plans; Kaiser Permanente HMO Plans and non-medical benefits.

2015-2016 PLAN YEAR UPDATE

Preferred Provider Organization (PPO) and Pharmacy Plans
Medical and pharmacy rate sheets are included. 2015-2016 plan matrices are available at ***http://www.cvtrust.org/products/medical-plans****.*

PPO Plans and Affordable Care Act (ACA) Required Changes
All plans will continue to comply with the regulations and the requirements of the Affordable Care Act (ACA). Health reform fees added approximately 0.5% to the overall PPO renewal for actives and retirees.

High Deductible Health Plans (HDHP)
A new Health Savings Account compliant PPO HDHP 3 will be added to the two existing HDHP plans.

In order to remain in compliance with the requirements set by the IRS, CVT will be adjusting HDHP Plan 1. The plan's current deductible for an individual is $1,250. The new minimum individual deductible requirement will be $1,300 in 2015-16.

Emergency Room (ER) Copay Increase
Given the static nature of copays relative to the ever increasing cost of care, the emergency room copay will increase from $75 to $100. The copay will continue to be waived if an individual is admitted.

The value of CVT's existing $75 copay has eroded over time as the cost of an ER visit has increased to an average of $2,344 per visit. The current ER copay represents just 3% of the cost of service. Data from Mercer's National Survey of Employer-Sponsored Health Plans shows that the national median ER copay amount in 2014 was $150.

Reference Based Benefits
CVT will implement a Reference Based Benefit (RBB) for all Anthem PPO plans for the following inpatient procedures: Hip Replacement, Hysterectomy, Knee Replacement and Laminectomy.

Under this benefit, a price cap will be set on the maximum amount the plan will cover for these medical services that have wide cost variations. The reference price for each procedure will be set at the 50th percentile for a given geography, based on Anthem's National Consumer Cost tool.

There can be big differences in cost between medical providers for the same care. That's why CVT is incorporating Reference Based Benefits – to help shrink the wide spread in what providers charge for services. When it comes to health care, higher cost doesn't always mean better quality. This program allows members to be engaged in their health care and make better-informed choices. It does this by helping a member choose health care providers with the best value without having to sacrifice on quality or care options.

We will launch a comprehensive communication plan soon to educate districts, chapters and members about Reference Based Benefits.

Kaiser Permanente HMO Plans

Medical and pharmacy rate sheets are included. 2015-2016 plan matrices are available at ***http://www.cvtrust.org/products/medical-plans****.*

Kaiser Permanente HMO Plans and ACA Required Changes

All plans will continue to comply with the regulations and the requirements of the Affordable Care Act (ACA). Health reform fees added approximately 1.3% to 1.6 % to the overall renewal.

DENTAL, VISION, EAP AND GROUP TERM LIFE/AD&D

CVT is committed to provide a comprehensive benefit package at a competitive and sustainable rate. As part of this, CVT's rating practice for dental and vision is being changed effective October 1 to be consistent with the medical rating policy.

After a thorough review and careful consideration, CVT will fully implement separate rate analysis for actives and retirees beginning October 1, 2015. CVT will charge districts/units different premiums for actives and for retired employees.

Delta Dental

Dental rates for Actives will NOT be changing.
Dental rates for Retirees will increase overall by +7.7%.

Vision Service Plan (VSP)

Vision rates for Actives will decrease overall by -3.9%.
Vision rates for Retirees will increase overall by +29.4%.

ValueOptions Employee Assistance Program (EAP)

EAP rates will increase from $1.13 to $1.16 per member per month for Districts/Units who purchase this benefit.

CVT will continue to provide EAP at no additional charge for all members with PPO or HMO medical coverage through CVT.

MetLife Group Term Life and AD&D Insurance

Life/AD&D rates will NOT be changing.

MAKING CHANGES TO BENEFITS

Receiving the new rates and benefit design changes for 2015-16 may be only the first step to preparing for next year. Information is included below to assist Districts/Units in making any necessary benefit changes for the 2015-16 plan year.

Important Dates and Deadlines

- **May** – Rates and benefit changes released to Districts/Units
- **August 15** – Plan modifications must be received by CVT for an October 1 effective date

  Note: If unable to make the August 15, 2015 deadline, plan modifications can be requested anytime with a 45 day notice during the year if they are due to completion of negotiations.
- **September** – CVT Annual Open Enrollment Period
- **October 1** – New plan year begins and the 2015-16 rates and benefit changes take effect

How do you make changes to your benefits?

To request a change, CVT requires a jointly signed letter by both the Unit representative or President and the District Superintendent. A jointly signed letter must be received by CVT 45 days prior to the requested effective date which must be the first day of a month. For example: If desired effective date is November 1, the jointly signed letter must be received by CVT no later than September 15. If the change is made outside the normal or usual October 1st effective date, a special open enrollment period can be requested if needed.

What does the jointly signed letter need to include and where do you send it?

- Effective date of change
- New plan additions or existing plan modification being made
- Notification of any changes to the rate structure (e.g. composite to tiered) for each line of coverage and each Unit. Remember each line of coverage and each Unit can choose different rate structures as long as it is consistent. Actives and retirees may have different rate structures.
- List of plans/benefits that will remain unchanged (if applicable)
- Request for a special open enrollment, if needed
- Letter may be mailed, faxed or emailed to the attention of your CVT Account Manager: Dave Koop at **davidk@cvtrust.org**, Eric Fiedler at **ericf@cvtrust.org**, Pam Oliveto at **pamo@cvtrust.org** or Tierney O'Brien at **tierneyo@cvtrust.org**. The CVT mailing address is **520 E. Herndon Ave., Fresno, CA 93720** and the fax number is **(559) 437-2965**.

What choices are there in making changes?

Below is a list of plans available for each line of coverage. Contact your Account Manager for additional information. New medical plan matrices are available at **www.cvtrust.org/products/medical-plans.**

PPO Medical Plans

- Each Unit may choose up to 4 of the 10 available PPO Plans.
- Each medical plan must be paired with one of the four available pharmacy plans.
- Each Unit may also add the Wellness PPO Plan as the fifth option and one of three High Deductible Health Plans (HDHP).
- The CVT Bronze PPO Plan is automatically included with all plans offered.
- A total of seven PPO plans could potentially be offered to each Unit.

Kaiser Permanente HMO Medical Plans

- Each Unit can choose to offer up to 4 of the 10 available Kaiser HMO plans.
- Each Unit may also add the Kaiser Wellness Plan as a fifth option.
- A total of 5 Kaiser Permanente plans could potentially be offered to each Unit.
- Plans available only for individuals living or working in a Kaiser approved zip code.

Delta Dental

- Each Unit can choose to offer one Basic Standard Incentive Plan and one PPO plan.
- Plans may be customized by adding additional benefits to either plan.

Vision Service Plan (VSP)

- Each Unit can choose to offer one of a number of options from one of the available plans.
- Plans differ by frequency of benefits and copays.

CALIFORNIA'S VALUED TRUST

2015/2016 District Rate Sheet

For Oak Park Unified SD

Health Three Tier Rates	Empl Only 2015/2016	Empl+One 2015/2016	Empl+Family 2015/2016	Pct Chg
CVT Bronze Plan	$404.00	$695.00	$877.00	7.7%
HDHP 1	$592.00	$1,018.00	$1,285.00	7.6%
KS 1 Active Chiro	$536.16	$922.31	$1,164.84	0.0%
KS 2 Active Chiro	$521.16	$897.31	$1,133.84	0.0%
KS 6 Active Chiro	$501.16	$863.31	$1,090.84	0.0%
PPO-1, RX-B	$863.00	$1,484.00	$1,873.00	7.9%
PPO-3, RX-B	$798.00	$1,372.00	$1,732.00	8.1%
PPO-5, RX-B	$759.00	$1,305.00	$1,647.00	7.3%
PPO-7, RX-B	$704.00	$1,210.00	$1,528.00	7.7%
WELL-1, RX-C	$715.00	$1,230.00	$1,552.00	7.4%

Dental Three Tier Rates	Empl Only 2015/2016	Empl+One 2015/2016	Empl+Family 2015/2016	Pct Chg
Basic, $2,000 Annual Maximum, Ortho 50/50 Adults & Children $1,000 Lifetime Max	$61.56	$113.84	$175.37	0.0%

Vision Three Tier Rates	Empl Only 2015/2016	Empl+One 2015/2016	Empl+Family 2015/2016	Pct Chg
Plan B $15.00 Deductible	$8.39	$15.53	$22.95	-3.9%

Monday, May 18, 2015

CALIFORNIA'S VALUED TRUST
PPO HEALTH PLANS
October 1, 2015 – September 30, 2016

BENEFIT	PPO PLAN 1		PPOPLAN 3		PPO PLAN 5		PPO PLAN 7			
Calendar Year Deductible	$0		Individual: $100 Family: $300		Individual: $100 Family: $300		Individual: $250 Family: $750			
Coinsurance	Paid at 100%*		Paid at 100%* after deductible is met		Paid at 90%* after deductible is met		Paid at 80%* after deductible is met			
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical & pharmacy copays) †	Individual: $1,250		Individual: $1,250		Individual: $1,250		Individual: $2,000			
	Family: $12,700									
Doctor Visits (Primary Care Physician)	$10 Copay		$20 Copay		$30 Copay		$30 Copay			
Doctor Visits (Specialty Physician)	$10 Copay		$20 Copay		$30 Copay		$30 Copay			
Preventive Care/Immunizations	Paid at 100%*									
Outpatient Diagnostic Tests / Imaging	Paid at 100%*		Paid at 100%* after deductible is met		Paid at 90%* after deductible		Paid at 80%* after deductible is met			
Radiation Therapy, Chemotherapy	Paid at 100%*		Paid at 100%* after deductible is met		Paid at 90%* after deductible is met		Paid at 80%* after deductible is met			
Durable Medical Equipment	Paid at 100%*		Paid at 100%* after deductible is met		Paid at 90%* after deductible is met		Paid at 80%* after deductible is met			
Ambulance – Ground/Air	Paid at 100%* of covered charges		Paid at 100%* after deductible is met		Paid at 90%* after deductible is met		Paid at 80%* after deductible is met			
Physical Therapy**	Paid at 100%* (Copay , if applicable.)		Paid at 100%* after deductible is met (Copay, if applicable.)		Paid at 90%* after deductible is met (Copay, if applicable.)		Paid at 80%* after deductible is met (Copay, if applicable.)			

Page 2	PPO PLAN 1	PPO PLAN 3	PPO PLAN 5	PPO PLAN 7
Chiropractic**	Paid at 100%* (Copay, if applicable)	Paid at 100%* after deductible is met (Copay, if applicable)	Paid at 90%* after deductible is met (Copay, if applicable)	Paid at 80%* after deductible is met (Copay, if applicable)
Acupuncture	Paid at 100%* (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 100%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 80%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year
Outpatient Surgery	Paid at 100%*	Paid at 100%* after deductible is met	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met
Hospital Inpatient (RBB price cap) ‡	Paid at 100%* Unlimited days, Semi- private room	Paid at 100%* after deductible is met Unlimited days, Semi-private room	Paid at 90%* after deductible is met Unlimited days, Semi- private room	Paid at 80%* after deductible is met Unlimited days, Semi-private room
Hospital Emergency Room	$100 Copay (Copay waived if admitted as in-patient) Paid at 100%*	$100 Copay (Copay waived if admitted as in-patient) Paid at 100%* after deductible is met	$100 Copay (Copay waived if admitted as in-patient) Paid at 90%* after deductible is met	$100 Copay (Copay waived if admitted as in-patient) Paid at 80%* after deductible is met
Urgent Care	$10 Copay	$20 Copay	$30 Copay	$30 Copay
Home Health Care	Paid at 100%* Limited to 100 visits per calendar year	Paid at 100%* after deductible is met Limited to 100 visits per calendar year	Paid at 90%* after deductible is met Limited to 100 visits per calendar year	Paid at 80%* after deductible is met Limited to 100 visits per calendar year
Telemedicine	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.			
Employee Assistance Program (EAP) through ValueOptions ~	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit			

***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.

****** Non-Par Providers limited to a combined maximum of 13 visits per year.**

† The pharmacy copayments will not apply to out of pocket maximums for retirees enrolled in CVT's Medicare Part D program through SilverScript.

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

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

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

CVT offers to its member districts a select menu of PPO plans. A district/unit will be able to choose up to four PPO plans, the Wellness Plan, plus one High Deductible Health Plan (HDHP) chosen from the menu of plans offered for the 2015-2016 plan year. The CVT Bronze Plan will automatically be included with all plans offered.

Below you will find the information regarding the plan design and the choices each unit will be able to choose from. You will see a range of choices from a 100% plan to a catastrophic, major medical plan.

PPO HEALTH PLAN OPTIONS

2015 - 2016

PLAN NAME		1		3		5		7			
CALENDAR YEAR DEDUCTIBLE	Individual	$0		$100		$100		$250			
	Family	$0		$300		$300		$750			
COINSURANCE		Paid at 100%		Paid at 100%		Paid at 90%		Paid at 80%			
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	Individual	$1,250		$1,250		$1,250		$2,000			
	Family	$12,700 Affordable Care Act (ACA) mandated Out of Pocket Maximum									
OFFICE VISIT COPAY		$10		$20		$30		$30			

All plans include annual physical, $100 emergency room copay, and chiropractic.

PRESCRIPTION PLAN OPTIONS

PLAN NAME		B		
An Rx plan should be chosen for each PPO Plan.		**Retail:** $7 Generic $15 Preferred $30 Non-Preferred **Mail Order:** $15 Generic $35 Preferred $70 Non-Preferred		

CALIFORNIA'S VALUED TRUST
PPO WELLNESS PLAN
October 1, 2015 – September 30, 2016

BENEFIT	PPO WELLNESS PLAN
Calendar Year Deductible	Individual: $500 Family: $1,000
Coinsurance	Paid at 90%* after deductible is met
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical & pharmacy copays) †	Individual: $1,750 Family: $12,700
Doctor Visits (Primary Care Physician)	$20 Copay
Doctor Visits (Specialty Physician)	$40 Copay
Preventive Care / Immunizations	Paid at 100%*
Outpatient Diagnostic Tests / Imaging	Paid at 90%* after deductible is met
Radiation Therapy, Chemotherapy	Paid at 90%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met
Ambulance – Ground / Air	Paid at 90%* after deductible is met
Physical Therapy**	Paid at 90%* after deductible is met (Copay, if applicable)

Page 2	PPO WELLNESS PLAN	
Chiropractic**	Paid at 90%* after deductible is met (Copay, if applicable)	
Acupuncture	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	
Outpatient Surgery	Paid at 90%* after deductible is met	
Hospital Inpatient (RBB price cap) ǂ	Paid at 90%* after deductible is met Unlimited days, semi-private room	
Hospital Emergency Room	$100 Copay (copay waived if admitted as in-patient) Paid at 90%* after deductible is met	
Urgent Care	$20 Copay	
Home Health Care	Paid at 90%* after deductible is met Limited to 100 visits per calendar year	
Telemedicine	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	
Employee Assistance Program (EAP) through ValueOptions ~	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	
Prescription Drugs	**Retail** $7 Generic $25 Preferred $40 Non-Preferred (30-day supply)	**Mail Order** $15 Generic $60 Preferred $90 Non-Preferred (90-day supply)

***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.**

** Non-Par Providers limited to a combined maximum of 13 visits per year.

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

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

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

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

CALIFORNIA'S VALUED TRUST
PPO HIGH DEDUCTIBLE HEALTH PLANS (HDHP)
October 1, 2015 – September 30, 2016

BENEFIT	HDHP 1		
Calendar Year Deductible	Individual: $1,300 Family: $3,000 (No individual limit applies to family)		
Coinsurance	Paid at 80%* after deductible is met		
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical & pharmacy copays) †	Individual: $4,250 Family: $10,100 Family = Employee with 1 or more covered dependents		
Doctor Visits (Primary Care Physician)	Paid at 80%* after deductible is met		
Doctor Visits (Specialty Physician)	Paid at 80%* after deductible is met		
Preventive Care / Immunizations	Paid at 100%*		
Outpatient Diagnostic Tests / Imaging	Paid at 80%* after deductible is met		
Radiation Therapy, Chemotherapy	Paid at 80%* after deductible is met		
Durable Medical Equipment	Paid at 80%* after deductible is met		
Ambulance – Ground / Air	Paid at 80%* after deductible is met		

Page 2	HDHP 1		
Physical Therapy **	Paid at 80%* after deductible is met		
Chiropractic**	Paid at 80%* after deductible is met		
Acupuncture	Paid at 80%* after deductible is met Maximum of 12 visits per calendar year		
Outpatient Surgery	Paid at 80%* after deductible is met		
Hospital Inpatient (RBB price cap) ǂ	Paid at 80%* after deductible is met; Unlimited days, semi-private room		
Hospital Emergency Room	Paid at 80%* after deductible is met		
Urgent Care	Paid at 80%* after deductible is met		
Home Health Care	Paid at 80%* after deductible is met Limited to 100 visits per calendar year		
Telemedicine	MDLIVE – Paid at 80%* after deductible is met Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		
Employee Assistance Program (EAP) through ValueOptions ~	Paid at 100% - Go to **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit		
Prescription Drugs	Paid at 80%* after deductible is met		

***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.**

** Non-Par Providers limited to a combined maximum of 13 visits per year.

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

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

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

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PPO BRONZE PLAN
October 1, 2015 – September 30, 2016

BENEFIT	PPO BRONZE PLAN
Calendar Year Deductible	Individual: $5,000 Family: $10,000
Coinsurance	Paid at 70%* after deductible is met
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical & pharmacy copays) †	Individual: $6,350 Family: $12,700
Doctor Visits (Primary Care Physician)	First 3 visits covered in full after $60 copay per visit Remaining visits paid at 70%* after deductible is met
Doctor Visits (Specialty Physician)	Subject to deductible, then $70 copay
Preventive Care / Immunizations	Paid at 100%*
Outpatient Diagnostic Tests / Imaging	Paid at 70%* after deductible is met
Radiation Therapy, Chemotherapy	Paid at 70%* after deductible is met
Durable Medical Equipment	Paid at 70%* after deductible is met
Ambulance – Ground / Air	Paid at 70* after deductible is met
Physical Therapy **	Paid at 70%* after deductible is met

Page 2	PPO BRONZE PLAN	
Chiropractic**	Paid at 70%* after deductible is met	
Acupuncture	Paid at 70%* after deductible is met Maximum of 12 visits per calendar year	
Outpatient Surgery	Paid at 70%* after deductible is met	
Hospital Inpatient (RBB price cap) ‡	Paid at 70%* after deductible is met; Unlimited days, semi-private room	
Hospital Emergency Room	Subject to deductible, then $250 copay (copay waived if admitted as in-patient)	
Urgent Care	Subject to deductible, then $120 copay	
Home Health Care	Paid at 70%* after deductible is met Limited to 100 visits per calendar year	
Telemedicine	MDLIVE - $5 copay Call **1-888-632-2738** or visit **www.mdlive.com/CVT** for non-emergency medical conditions	
Employee Assistance Program (EAP) through ValueOptions ~	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	
Prescription Drugs	**Retail** Subject to deductible, then $25 Generic Copay $50 Brand Copay (30- day supply)	**Mail Order** Subject to deductible, then $50 Generic Copay $100 Brand Copay (90- day supply)

***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.

** Non-Par Providers limited to a combined maximum of 13 visits per year.

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

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

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

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
KAISER PERMANENTE HEALTH / RX PLANS
October 1, 2015 – September 30, 2016

BENEFIT	KAISER 1	KAISER 2				KAISER 6 w/ Optical Benefit		
Calendar Year Deductible	$0	$0				$0		
Coinsurance	Paid at 100%*	Paid at 100%*				Paid at 100%*		
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical & pharmacy copays) †	Individual: $1,500 Family: $3,000	Individual: $1,500 Family: $3,000				Individual: $1,500 Family: $3,000		
Doctor Visits (Primary Care Physician)	$10 Copay	$15 Copay				$25 Copay		
Doctor Visits (Specialty Physician)	$10 Copay	$15 Copay				$25 Copay		
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*				Paid at 100%*		
Outpatient Diagnostic Tests / Imaging	Paid at 100%*	Paid at 100%*				Paid at 100%*		
Radiation Therapy, Chemotherapy	Radiation Therapy: Paid at 100%* Chemotherapy: $10 Copay	Radiation Therapy: Paid at 100%* Chemotherapy: $15 Copay				Radiation Therapy: Paid at 100%* Chemotherapy: $25 Copay		
Durable Medical Equipment	Paid at 100%*	Paid at 100%*				Paid at 100%*		
Ambulance – Ground/Air	Paid at 100%* If Medically Necessary	Paid at 100%* If Medically Necessary				$50 Per Trip If Medically Necessary		
Physical Therapy	$10 Copay	$15 Copay				$25 Copay		
Chiropractic	Not Covered	Not Covered				Not Covered		

Page 2	KAISER 1	KAISER 2				KAISER 6 w/ Optical Benefit		
Acupuncture	$10 Copay Referral by Plan Physician	$15 Copay Referral by Plan Physician				$25 Copay Referral by Plan Physician		
Outpatient Surgery	$10 Copay	$15 Copay				$25 Copay		
Hospital Inpatient	Paid at 100%*	Paid at 100%*				$250 Copay		
Hospital Emergency Room	$35 Copay Copay waived if admitted as in-patient	$50 Copay Copay waived if admitted as in-patient				$50 Copay Copay waived if admitted as in-patient		
Urgent Care	$10 Copay	$15 Copay				$25 Copay		
Home Health Care	Paid at 100%* (Limits)	Paid at 100%* (Limits)				Paid at 100%* (Limits)		
Telemedicine	For after-hours advice, call 1-888-576-6225	For after-hours advice, call 1-888-576-6225				For after-hours advice, call 1-888-576-6225		
Employee Assistance Program (EAP) through ValueOptions ~	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit				Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit		
Prescription Drugs	Retail $5 Generic $10 Brand (Up to 30 Day Supply) $10 Generic $20 Brand (31- 60 Day Supply) $15 Generic $30 Brand (61-100 Day Supply) Mail Order $5 Generic $10 Brand (30 Day Supply) $10 Generic $20 Brand (31-100 Day Supply)	Retail $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)		

*** For Covered Expenses Only**

† The pharmacy copayments will not apply to out of pocket maximums for retirees enrolled in a Medicare Senior Advantage Plan.

NOTES: Copays for Infertility: Plans 1 – $10 Copay; Plan 2 - $15 Copay; Plan 3 – 50% Copay; Plan 4 - $30 Copay; Plan 5 - $35 Copay; Plans 6-8 – 50% Copay.
Copays for Allergy Injections: Plans 1-5 – No Charge; Plans 6-7 - $5 Per Visit; Plan 8 – No Charge.
Plan 6 - $175 allowance for lenses, frames & contacts every 24 months

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

This summary is for comparison purposes only. Please refer to the Evidence of Coverage for complete benefits at www.cvtrust.org/plan-documents

CVT Benefits Plan

Anthem Blue Cross PPO Plan 1B

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	10,356.00	738.72	100.68	11,195.40	$7,371.00	3,824.40	382.44	6,633.90	4,561.50	456.15
Employee Only	Emp+1	Emp+1	10,356.00	1,366.08	186.36	11,908.44	$7,371.00	4,537.44	453.74	6,633.90	5,274.54	527.45
Employee Only	Family	Family	10,356.00	2,104.44	275.40	12,735.84	$7,371.00	5,364.84	536.48	6,633.90	6,101.94	610.19
Employee+1 Dependent	Emp	Emp	17,808.00	738.72	100.68	18,647.40	$12,724.00	5,923.40	592.34	11,451.60	7,195.80	719.58
Employee+1 Dependent	Emp+1	Emp+1	17,808.00	1,366.08	186.36	19,360.44	$12,724.00	6,636.44	663.64	11,451.60	7,908.84	790.88
Employee+1 Dependent	Family	Family	17,808.00	2,104.44	275.40	20,187.84	$12,724.00	7,463.84	746.38	11,451.60	8,736.24	873.62
Family Coverage	Emp	Emp	22,476.00	738.72	100.68	23,315.40	$16,483.00	6,832.40	683.24	14,834.70	8,480.70	848.07
Family Coverage	Emp+1	Emp+1	22,476.00	1,366.08	186.36	24,028.44	$16,483.00	7,545.44	754.54	14,834.70	9,193.74	919.37
Family Coverage	Family	Family	22,476.00	2,104.44	275.40	24,855.84	$16,483.00	8,372.84	837.28	14,834.70	10,021.14	1,002.11

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	5,896.80	5,298.60	529.86	5,528.25	5,667.15	566.72	4,422.60	6,772.80	677.28	3,685.50	7,509.90	750.99
Employee Only	Emp+1	Emp+1	5,896.80	6,011.64	601.16	5,528.25	6,380.19	638.02	4,422.60	7,485.84	748.58	3,685.50	8,222.94	822.29
Employee Only	Family	Family	5,896.80	6,839.04	683.90	5,528.25	7,207.59	720.76	4,422.60	8,313.24	831.32	3,685.50	9,050.34	905.03
Employee+1 Dependent	Emp	Emp	10,179.20	8,468.20	846.82	9,543.00	9,104.40	910.44	7,634.40	11,013.00	1,101.30	6,362.00	12,285.40	1,228.54
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	9,181.24	918.12	9,543.00	9,817.44	981.74	7,634.40	11,726.04	1,172.60	6,362.00	12,998.44	1,299.84
Employee+1 Dependent	Family	Family	10,179.20	10,008.64	1,000.86	9,543.00	10,644.84	1,064.48	7,634.40	12,553.44	1,255.34	6,362.00	13,825.84	1,382.58
Family Coverage	Emp	Emp	13,186.40	10,129.00	1,012.90	12,362.25	10,953.15	1,095.32	9,889.80	13,425.60	1,342.56	8,241.50	15,073.90	1,507.39
Family Coverage	Emp+1	Emp+1	13,186.40	10,842.04	1,084.20	12,362.25	11,666.19	1,166.62	9,889.80	14,138.64	1,413.86	8,241.50	15,786.94	1,578.69
Family Coverage	Family	Family	13,186.40	11,669.44	1,166.94	12,362.25	12,493.59	1,249.36	9,889.80	14,966.04	1,496.60	8,241.50	16,614.34	1,661.43

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 for employee plus two or more dependents. Eligible part-time employees receive a pro-rata share of the annual allowance. A monthly payroll deduction will be taken September through June for employees who select a plan that exceeds the selected cap.

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

CVT Benefits Plan

Anthem Blue Cross PPO Plan 3B

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	9,576.00	738.72	100.68	10,415.40	$7,371.00	3,044.40	304.44	6,633.90	3,781.50	378.15
Employee Only	Emp+1	Emp+1	9,576.00	1,366.08	186.36	11,128.44	$7,371.00	3,757.44	375.74	6,633.90	4,494.54	449.45
Employee Only	Family	Family	9,576.00	2,104.44	275.40	11,955.84	$7,371.00	4,584.84	458.48	6,633.90	5,321.94	532.19
Employee+1 Dependent	Emp	Emp	16,464.00	738.72	100.68	17,303.40	$12,724.00	4,579.40	457.94	11,451.60	5,851.80	585.18
Employee+1 Dependent	Emp+1	Emp+1	16,464.00	1,366.08	186.36	18,016.44	$12,724.00	5,292.44	529.24	11,451.60	6,564.84	656.48
Employee+1 Dependent	Family	Family	16,464.00	2,104.44	275.40	18,843.84	$12,724.00	6,119.84	611.98	11,451.60	7,392.24	739.22
Family Coverage	Emp	Emp	20,784.00	738.72	100.68	21,623.40	$16,483.00	5,140.40	514.04	14,834.70	6,788.70	678.87
Family Coverage	Emp+1	Emp+1	20,784.00	1,366.08	186.36	22,336.44	$16,483.00	5,853.44	585.34	14,834.70	7,501.74	750.17
Family Coverage	Family	Family	20,784.00	2,104.44	275.40	23,163.84	$16,483.00	6,680.84	668.08	14,834.70	8,329.14	832.91

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	5,896.80	4,518.60	451.86	5,528.25	4,887.15	488.72	4,422.60	5,992.80	599.28	3,685.50	6,729.90	672.99
Employee Only	Emp+1	Emp+1	5,896.80	5,231.64	523.16	5,528.25	5,600.19	560.02	4,422.60	6,705.84	670.58	3,685.50	7,442.94	744.29
Employee Only	Family	Family	5,896.80	6,059.04	605.90	5,528.25	6,427.59	642.76	4,422.60	7,533.24	753.32	3,685.50	8,270.34	827.03
Employee+1 Dependent	Emp	Emp	10,179.20	7,124.20	712.42	9,543.00	7,760.40	776.04	7,634.40	9,669.00	966.90	6,362.00	10,941.40	1,094.14
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	7,837.24	783.72	9,543.00	8,473.44	847.34	7,634.40	10,382.04	1,038.20	6,362.00	11,654.44	1,165.44
Employee+1 Dependent	Family	Family	10,179.20	8,664.64	866.46	9,543.00	9,300.84	930.08	7,634.40	11,209.44	1,120.94	6,362.00	12,481.84	1,248.18
Family Coverage	Emp	Emp	13,186.40	8,437.00	843.70	12,362.25	9,261.15	926.12	9,889.80	11,733.60	1,173.36	8,241.50	13,381.90	1,338.19
Family Coverage	Emp+1	Emp+1	13,186.40	9,150.04	915.00	12,362.25	9,974.19	997.42	9,889.80	12,446.64	1,244.66	8,241.50	14,094.94	1,409.49
Family Coverage	Family	Family	13,186.40	9,977.44	997.74	12,362.25	10,801.59	1,080.16	9,889.80	13,274.04	1,327.40	8,241.50	14,922.34	1,492.23

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	9,108.00	738.72	100.68	9,947.40	$7,371.00	2,576.40	257.64	6,633.90	3,313.50	331.35
Employee Only	Emp+1	Emp+1	9,108.00	1,366.08	186.36	10,660.44	$7,371.00	3,289.44	328.94	6,633.90	4,026.54	402.65
Employee Only	Family	Family	9,108.00	2,104.44	275.40	11,487.84	$7,371.00	4,116.84	411.68	6,633.90	4,853.94	485.39
Employee+1 Dependent	Emp	Emp	15,660.00	738.72	100.68	16,499.40	$12,724.00	3,775.40	377.54	11,451.60	5,047.80	504.78
Employee+1 Dependent	Emp+1	Emp+1	15,660.00	1,366.08	186.36	17,212.44	$12,724.00	4,488.44	448.84	11,451.60	5,760.84	576.08
Employee+1 Dependent	Family	Family	15,660.00	2,104.44	275.40	18,039.84	$12,724.00	5,315.84	531.58	11,451.60	6,588.24	658.82
Family Coverage	Emp	Emp	19,764.00	738.72	100.68	20,603.40	$16,483.00	4,120.40	412.04	14,834.70	5,768.70	576.87
Family Coverage	Emp+1	Emp+1	19,764.00	1,366.08	186.36	21,316.44	$16,483.00	4,833.44	483.34	14,834.70	6,481.74	648.17
Family Coverage	Family	Family	19,764.00	2,104.44	275.40	22,143.84	$16,483.00	5,660.84	566.08	14,834.70	7,309.14	730.91

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	5,896.80	4,050.60	405.06	5,528.25	4,419.15	441.92	4,422.60	5,524.80	552.48	3,685.50	6,261.90	626.19
Employee Only	Emp+1	Emp+1	5,896.80	4,763.64	476.36	5,528.25	5,132.19	513.22	4,422.60	6,237.84	623.78	3,685.50	6,974.94	697.49
Employee Only	Family	Family	5,896.80	5,591.04	559.10	5,528.25	5,959.59	595.96	4,422.60	7,065.24	706.52	3,685.50	7,802.34	780.23
Employee+1 Dependent	Emp	Emp	10,179.20	6,320.20	632.02	9,543.00	6,956.40	695.64	7,634.40	8,865.00	886.50	6,362.00	10,137.40	1,013.74
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	7,033.24	703.32	9,543.00	7,669.44	766.94	7,634.40	9,578.04	957.80	6,362.00	10,850.44	1,085.04
Employee+1 Dependent	Family	Family	10,179.20	7,860.64	786.06	9,543.00	8,496.84	849.68	7,634.40	10,405.44	1,040.54	6,362.00	11,677.84	1,167.78
Family Coverage	Emp	Emp	13,186.40	7,417.00	741.70	12,362.25	8,241.15	824.12	9,889.80	10,713.60	1,071.36	8,241.50	12,361.90	1,236.19
Family Coverage	Emp+1	Emp+1	13,186.40	8,130.04	813.00	12,362.25	8,954.19	895.42	9,889.80	11,426.64	1,142.66	8,241.50	13,074.94	1,307.49
Family Coverage	Family	Family	13,186.40	8,957.44	895.74	12,362.25	9,781.59	978.16	9,889.80	12,254.04	1,225.40	8,241.50	13,902.34	1,390.23

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	8,448.00	738.72	100.68	9,287.40	$7,371.00	1,916.40	191.64	6,633.90	2,653.50	265.35
Employee Only	Emp+1	Emp+1	8,448.00	1,366.08	186.36	10,000.44	$7,371.00	2,629.44	262.94	6,633.90	3,366.54	336.65
Employee Only	Family	Family	8,448.00	2,104.44	275.40	10,827.84	$7,371.00	3,456.84	345.68	6,633.90	4,193.94	419.39
Employee+1 Dependent	Emp	Emp	14,520.00	738.72	100.68	15,359.40	$12,724.00	2,635.40	263.54	11,451.60	3,907.80	390.78
Employee+1 Dependent	Emp+1	Emp+1	14,520.00	1,366.08	186.36	16,072.44	$12,724.00	3,348.44	334.84	11,451.60	4,620.84	462.08
Employee+1 Dependent	Family	Family	14,520.00	2,104.44	275.40	16,899.84	$12,724.00	4,175.84	417.58	11,451.60	5,448.24	544.82
Family Coverage	Emp	Emp	18,336.00	738.72	100.68	19,175.40	$16,483.00	2,692.40	269.24	14,834.70	4,340.70	434.07
Family Coverage	Emp+1	Emp+1	18,336.00	1,366.08	186.36	19,888.44	$16,483.00	3,405.44	340.54	14,834.70	5,053.74	505.37
Family Coverage	Family	Family	18,336.00	2,104.44	275.40	20,715.84	$16,483.00	4,232.84	423.28	14,834.70	5,881.14	588.11

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	5,896.80	3,390.60	339.06	5,528.25	3,759.15	375.92	4,422.60	4,864.80	486.48	3,685.50	5,601.90	560.19
Employee Only	Emp+1	Emp+1	5,896.80	4,103.64	410.36	5,528.25	4,472.19	447.22	4,422.60	5,577.84	557.78	3,685.50	6,314.94	631.49
Employee Only	Family	Family	5,896.80	4,931.04	493.10	5,528.25	5,299.59	529.96	4,422.60	6,405.24	640.52	3,685.50	7,142.34	714.23
Employee+1 Dependent	Emp	Emp	10,179.20	5,180.20	518.02	9,543.00	5,816.40	581.64	7,634.40	7,725.00	772.50	6,362.00	8,997.40	899.74
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	5,893.24	589.32	9,543.00	6,529.44	652.94	7,634.40	8,438.04	843.80	6,362.00	9,710.44	971.04
Employee+1 Dependent	Family	Family	10,179.20	6,720.64	672.06	9,543.00	7,356.84	735.68	7,634.40	9,265.44	926.54	6,362.00	10,537.84	1,053.78
Family Coverage	Emp	Emp	13,186.40	5,989.00	598.90	12,362.25	6,813.15	681.32	9,889.80	9,285.60	928.56	8,241.50	10,933.90	1,093.39
Family Coverage	Emp+1	Emp+1	13,186.40	6,702.04	670.20	12,362.25	7,526.19	752.62	9,889.80	9,998.64	999.86	8,241.50	11,646.94	1,164.69
Family Coverage	Family	Family	13,186.40	7,529.44	752.94	12,362.25	8,353.59	835.36	9,889.80	10,826.04	1,082.60	8,241.50	12,474.34	1,247.43

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	8,580.00	738.72	100.68	9,419.40	$7,371.00	2,048.40	204.84	6,633.90	2,785.50	278.55
Employee Only	Emp+1	Emp+1	8,580.00	1,366.08	186.36	10,132.44	$7,371.00	2,761.44	276.14	6,633.90	3,498.54	349.85
Employee Only	Family	Family	8,580.00	2,104.44	275.40	10,959.84	$7,371.00	3,588.84	358.88	6,633.90	4,325.94	432.59
Employee+1 Dependent	Emp	Emp	14,760.00	738.72	100.68	15,599.40	$12,724.00	2,875.40	287.54	11,451.60	4,147.80	414.78
Employee+1 Dependent	Emp+1	Emp+1	14,760.00	1,366.08	186.36	16,312.44	$12,724.00	3,588.44	358.84	11,451.60	4,860.84	486.08
Employee+1 Dependent	Family	Family	14,760.00	2,104.44	275.40	17,139.84	$12,724.00	4,415.84	441.58	11,451.60	5,688.24	568.82
Family Coverage	Emp	Emp	18,624.00	738.72	100.68	19,463.40	$16,483.00	2,980.40	298.04	14,834.70	4,628.70	462.87
Family Coverage	Emp+1	Emp+1	18,624.00	1,366.08	186.36	20,176.44	$16,483.00	3,693.44	369.34	14,834.70	5,341.74	534.17
Family Coverage	Family	Family	18,624.00	2,104.44	275.40	21,003.84	$16,483.00	4,520.84	452.08	14,834.70	6,169.14	616.91

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	5,896.80	3,522.60	352.26	5,528.25	3,891.15	389.12	4,422.60	4,996.80	499.68	3,685.50	5,733.90	573.39
Employee Only	Emp+1	Emp+1	5,896.80	4,235.64	423.56	5,528.25	4,604.19	460.42	4,422.60	5,709.84	570.98	3,685.50	6,446.94	644.69
Employee Only	Family	Family	5,896.80	5,063.04	506.30	5,528.25	5,431.59	543.16	4,422.60	6,537.24	653.72	3,685.50	7,274.34	727.43
Employee+1 Dependent	Emp	Emp	10,179.20	5,420.20	542.02	9,543.00	6,056.40	605.64	7,634.40	7,965.00	796.50	6,362.00	9,237.40	923.74
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	6,133.24	613.32	9,543.00	6,769.44	676.94	7,634.40	8,678.04	867.80	6,362.00	9,950.44	995.04
Employee+1 Dependent	Family	Family	10,179.20	6,960.64	696.06	9,543.00	7,596.84	759.68	7,634.40	9,505.44	950.54	6,362.00	10,777.84	1,077.78
Family Coverage	Emp	Emp	13,186.40	6,277.00	627.70	12,362.25	7,101.15	710.12	9,889.80	9,573.60	957.36	8,241.50	11,221.90	1,122.19
Family Coverage	Emp+1	Emp+1	13,186.40	6,990.04	699.00	12,362.25	7,814.19	781.42	9,889.80	10,286.64	1,028.66	8,241.50	11,934.94	1,193.49
Family Coverage	Family	Family	13,186.40	7,817.44	781.74	12,362.25	8,641.59	864.16	9,889.80	11,114.04	1,111.40	8,241.50	12,762.34	1,276.23

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	7,104.00	738.72	100.68	7,943.40	$7,371.00	572.40	57.24	6,633.90	1,309.50	130.95
Employee Only	Emp+1	Emp+1	7,104.00	1,366.08	186.36	8,656.44	$7,371.00	1,285.44	128.54	6,633.90	2,022.54	202.25
Employee Only	Family	Family	7,104.00	2,104.44	275.40	9,483.84	$7,371.00	2,112.84	211.28	6,633.90	2,849.94	284.99
Employee+1 Dependent	Emp	Emp	12,216.00	738.72	100.68	13,055.40	$12,724.00	331.40	33.14	11,451.60	1,603.80	160.38
Employee+1 Dependent	Emp+1	Emp+1	12,216.00	1,366.08	186.36	13,768.44	$12,724.00	1,044.44	104.44	11,451.60	2,316.84	231.68
Employee+1 Dependent	Family	Family	12,216.00	2,104.44	275.40	14,595.84	$12,724.00	1,871.84	187.18	11,451.60	3,144.24	314.42
Family Coverage	Emp	Emp	15,420.00	738.72	100.68	16,259.40	$16,483.00	0.00	0.00	14,834.70	1,424.70	142.47
Family Coverage	Emp+1	Emp+1	15,420.00	1,366.08	186.36	16,972.44	$16,483.00	489.44	48.94	14,834.70	2,137.74	213.77
Family Coverage	Family	Family	15,420.00	2,104.44	275.40	17,799.84	$16,483.00	1,316.84	131.68	14,834.70	2,965.14	296.51

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	5,896.80	2,046.60	204.66	5,528.25	2,415.15	241.52	4,422.60	3,520.80	352.08	3,685.50	4,257.90	425.79
Employee Only	Emp+1	Emp+1	5,896.80	2,759.64	275.96	5,528.25	3,128.19	312.82	4,422.60	4,233.84	423.38	3,685.50	4,970.94	497.09
Employee Only	Family	Family	5,896.80	3,587.04	358.70	5,528.25	3,955.59	395.56	4,422.60	5,061.24	506.12	3,685.50	5,798.34	579.83
Employee+1 Dependent	Emp	Emp	10,179.20	2,876.20	287.62	9,543.00	3,512.40	351.24	7,634.40	5,421.00	542.10	6,362.00	6,693.40	669.34
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	3,589.24	358.92	9,543.00	4,225.44	422.54	7,634.40	6,134.04	613.40	6,362.00	7,406.44	740.64
Employee+1 Dependent	Family	Family	10,179.20	4,416.64	441.66	9,543.00	5,052.84	505.28	7,634.40	6,961.44	696.14	6,362.00	8,233.84	823.38
Family Coverage	Emp	Emp	13,186.40	3,073.00	307.30	12,362.25	3,897.15	389.72	9,889.80	6,369.60	636.96	8,241.50	8,017.90	801.79
Family Coverage	Emp+1	Emp+1	13,186.40	3,786.04	378.60	12,362.25	4,610.19	461.02	9,889.80	7,082.64	708.26	8,241.50	8,730.94	873.09
Family Coverage	Family	Family	13,186.40	4,613.44	461.34	12,362.25	5,437.59	543.76	9,889.80	7,910.04	791.00	8,241.50	9,558.34	955.83

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	4,848.00	738.72	100.68	5,687.40	$7,371.00	0.00	0.00	6,633.90	0.00	0.00
Employee Only	Emp+1	Emp+1	4,848.00	1,366.08	186.36	6,400.44	$7,371.00	0.00	0.00	6,633.90	0.00	0.00
Employee Only	Family	Family	4,848.00	2,104.44	275.40	7,227.84	$7,371.00	0.00	0.00	6,633.90	593.94	59.39
Employee+1 Dependent	Emp	Emp	8,340.00	738.72	100.68	9,179.40	$12,724.00	0.00	0.00	11,451.60	0.00	0.00
Employee+1 Dependent	Emp+1	Emp+1	8,340.00	1,366.08	186.36	9,892.44	$12,724.00	0.00	0.00	11,451.60	0.00	0.00
Employee+1 Dependent	Family	Family	8,340.00	2,104.44	275.40	10,719.84	$12,724.00	0.00	0.00	11,451.60	0.00	0.00
Family Coverage	Emp	Emp	10,524.00	738.72	100.68	11,363.40	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Emp+1	Emp+1	10,524.00	1,366.08	186.36	12,076.44	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Family	Family	10,524.00	2,104.44	275.40	12,903.84	$16,483.00	0.00	0.00	14,834.70	0.00	0.00

IF YOU SELECT THIS LEVEL OF HEALTH BENEFIT COVERAGE FOR YOURSELF AND DEPENDENTS:			0.8 FTE PAYROLL DEDUCTION			0.75 FTE PAYROLL DEDUCTION			0.60 FTE PAYROLL DEDUCTION			0.50 FTE PAYROLL DEDUCTION		
			Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction		Pro-rated	Payroll Deduction	
Medical	**Dental**	**Vision**	Cap (80%)	Annual	Monthly	Cap (75%)	Annual	Monthly	Cap (60%)	Annual	Monthly	Cap (50%)	Annual	Monthly
Employee Only	Emp	Emp	5,896.80	0.00	0.00	5,528.25	159.15	15.92	4,422.60	1,264.80	126.48	3,685.50	2,001.90	200.19
Employee Only	Emp+1	Emp+1	5,896.80	503.64	50.36	5,528.25	872.19	87.22	4,422.60	1,977.84	197.78	3,685.50	2,714.94	271.49
Employee Only	Family	Family	5,896.80	1,331.04	133.10	5,528.25	1,699.59	169.96	4,422.60	2,805.24	280.52	3,685.50	3,542.34	354.23
Employee+1 Dependent	Emp	Emp	10,179.20	0.00	0.00	9,543.00	0.00	0.00	7,634.40	1,545.00	154.50	6,362.00	2,817.40	281.74
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	0.00	0.00	9,543.00	349.44	34.94	7,634.40	2,258.04	225.80	6,362.00	3,530.44	353.04
Employee+1 Dependent	Family	Family	10,179.20	540.64	54.06	9,543.00	1,176.84	117.68	7,634.40	3,085.44	308.54	6,362.00	4,357.84	435.78
Family Coverage	Emp	Emp	13,186.40	0.00	0.00	12,362.25	0.00	0.00	9,889.80	1,473.60	147.36	8,241.50	3,121.90	312.19
Family Coverage	Emp+1	Emp+1	13,186.40	0.00	0.00	12,362.25	0.00	0.00	9,889.80	2,186.64	218.66	8,241.50	3,834.94	383.49
Family Coverage	Family	Family	13,186.40	0.00	0.00	12,362.25	541.59	54.16	9,889.80	3,014.04	301.40	8,241.50	4,662.34	466.23

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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))

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	6,433.92	738.72	100.68	7,273.32	$7,371.00	0.00	0.00	6,633.90	639.42	63.94
Employee Only	Emp+1	Emp+1	6,433.92	1,366.08	186.36	7,986.36	$7,371.00	615.36	61.54	6,633.90	1,352.46	135.25
Employee Only	Family	Family	6,433.92	2,104.44	275.40	8,813.76	$7,371.00	1,442.76	144.28	6,633.90	2,179.86	217.99
Employee+1 Dependent	Emp	Emp	11,067.72	738.72	100.68	11,907.12	$12,724.00	0.00	0.00	11,451.60	455.52	45.55
Employee+1 Dependent	Emp+1	Emp+1	11,067.72	1,366.08	186.36	12,620.16	$12,724.00	0.00	0.00	11,451.60	1,168.56	116.86
Employee+1 Dependent	Family	Family	11,067.72	2,104.44	275.40	13,447.56	$12,724.00	723.56	72.36	11,451.60	1,995.96	199.60
Family Coverage	Emp	Emp	13,978.08	738.72	100.68	14,817.48	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Emp+1	Emp+1	13,978.08	1,366.08	186.36	15,530.52	$16,483.00	0.00	0.00	14,834.70	695.82	69.58
Family Coverage	Family	Family	13,978.08	2,104.44	275.40	16,357.92	$16,483.00	0.00	0.00	14,834.70	1,523.22	152.32

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	5,896.80	1,376.52	137.65	5,528.25	1,745.07	174.51	4,422.60	2,850.72	285.07	3,685.50	3,587.82	358.78
Employee Only	Emp+1	Emp+1	5,896.80	2,089.56	208.96	5,528.25	2,458.11	245.81	4,422.60	3,563.76	356.38	3,685.50	4,300.86	430.09
Employee Only	Family	Family	5,896.80	2,916.96	291.70	5,528.25	3,285.51	328.55	4,422.60	4,391.16	439.12	3,685.50	5,128.26	512.83
Employee+1 Dependent	Emp	Emp	10,179.20	1,727.92	172.79	9,543.00	2,364.12	236.41	7,634.40	4,272.72	427.27	6,362.00	5,545.12	554.51
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	2,440.96	244.10	9,543.00	3,077.16	307.72	7,634.40	4,985.76	498.58	6,362.00	6,258.16	625.82
Employee+1 Dependent	Family	Family	10,179.20	3,268.36	326.84	9,543.00	3,904.56	390.46	7,634.40	5,813.16	581.32	6,362.00	7,085.56	708.56
Family Coverage	Emp	Emp	13,186.40	1,631.08	163.11	12,362.25	2,455.23	245.52	9,889.80	4,927.68	492.77	8,241.50	6,575.98	657.60
Family Coverage	Emp+1	Emp+1	13,186.40	2,344.12	234.41	12,362.25	3,168.27	316.83	9,889.80	5,640.72	564.07	8,241.50	7,289.02	728.90
Family Coverage	Family	Family	13,186.40	3,171.52	317.15	12,362.25	3,995.67	399.57	9,889.80	6,468.12	646.81	8,241.50	8,116.42	811.64

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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))

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	6,253.92	738.72	100.68	7,093.32	$7,371.00	0.00	0.00	6,633.90	459.42	45.94
Employee Only	Emp+1	Emp+1	6,253.92	1,366.08	186.36	7,806.36	$7,371.00	435.36	43.54	6,633.90	1,172.46	117.25
Employee Only	Family	Family	6,253.92	2,104.44	275.40	8,633.76	$7,371.00	1,262.76	126.28	6,633.90	1,999.86	199.99
Employee+1 Dependent	Emp	Emp	10,767.72	738.72	100.68	11,607.12	$12,724.00	0.00	0.00	11,451.60	155.52	15.55
Employee+1 Dependent	Emp+1	Emp+1	10,767.72	1,366.08	186.36	12,320.16	$12,724.00	0.00	0.00	11,451.60	868.56	86.86
Employee+1 Dependent	Family	Family	10,767.72	2,104.44	275.40	13,147.56	$12,724.00	423.56	42.36	11,451.60	1,695.96	169.60
Family Coverage	Emp	Emp	13,606.08	738.72	100.68	14,445.48	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Emp+1	Emp+1	13,606.08	1,366.08	186.36	15,158.52	$16,483.00	0.00	0.00	14,834.70	323.82	32.38
Family Coverage	Family	Family	13,606.08	2,104.44	275.40	15,985.92	$16,483.00	0.00	0.00	14,834.70	1,151.22	115.12

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	5,896.80	1,196.52	119.65	5,528.25	1,565.07	156.51	4,422.60	2,670.72	267.07	3,685.50	3,407.82	340.78
Employee Only	Emp+1	Emp+1	5,896.80	1,909.56	190.96	5,528.25	2,278.11	227.81	4,422.60	3,383.76	338.38	3,685.50	4,120.86	412.09
Employee Only	Family	Family	5,896.80	2,736.96	273.70	5,528.25	3,105.51	310.55	4,422.60	4,211.16	421.12	3,685.50	4,948.26	494.83
Employee+1 Dependent	Emp	Emp	10,179.20	1,427.92	142.79	9,543.00	2,064.12	206.41	7,634.40	3,972.72	397.27	6,362.00	5,245.12	524.51
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	2,140.96	214.10	9,543.00	2,777.16	277.72	7,634.40	4,685.76	468.58	6,362.00	5,958.16	595.82
Employee+1 Dependent	Family	Family	10,179.20	2,968.36	296.84	9,543.00	3,604.56	360.46	7,634.40	5,513.16	551.32	6,362.00	6,785.56	678.56
Family Coverage	Emp	Emp	13,186.40	1,259.08	125.91	12,362.25	2,083.23	208.32	9,889.80	4,555.68	455.57	8,241.50	6,203.98	620.40
Family Coverage	Emp+1	Emp+1	13,186.40	1,972.12	197.21	12,362.25	2,796.27	279.63	9,889.80	5,268.72	526.87	8,241.50	6,917.02	691.70
Family Coverage	Family	Family	13,186.40	2,799.52	279.95	12,362.25	3,623.67	362.37	9,889.80	6,096.12	609.61	8,241.50	7,744.42	774.44

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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))

2015-16 Health Benefits Cap and Estimated Payroll Deductions for Full Time and Part-Time 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	6,013.92	738.72	100.68	6,853.32	$7,371.00	0.00	0.00	6,633.90	219.42	21.94
Employee Only	Emp+1	Emp+1	6,013.92	1,366.08	186.36	7,566.36	$7,371.00	195.36	19.54	6,633.90	932.46	93.25
Employee Only	Family	Family	6,013.92	2,104.44	275.40	8,393.76	$7,371.00	1,022.76	102.28	6,633.90	1,759.86	175.99
Employee+1 Dependent	Emp	Emp	10,359.72	738.72	100.68	11,199.12	$12,724.00	0.00	0.00	11,451.60	0.00	0.00
Employee+1 Dependent	Emp+1	Emp+1	10,359.72	1,366.08	186.36	11,912.16	$12,724.00	0.00	0.00	11,451.60	460.56	46.06
Employee+1 Dependent	Family	Family	10,359.72	2,104.44	275.40	12,739.56	$12,724.00	15.56	1.56	11,451.60	1,287.96	128.80
Family Coverage	Emp	Emp	13,090.08	738.72	100.68	13,929.48	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Emp+1	Emp+1	13,090.08	1,366.08	186.36	14,642.52	$16,483.00	0.00	0.00	14,834.70	0.00	0.00
Family Coverage	Family	Family	13,090.08	2,104.44	275.40	15,469.92	$16,483.00	0.00	0.00	14,834.70	635.22	63.52

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	5,896.80	956.52	95.65	5,528.25	1,325.07	132.51	4,422.60	2,430.72	243.07	3,685.50	3,167.82	316.78
Employee Only	Emp+1	Emp+1	5,896.80	1,669.56	166.96	5,528.25	2,038.11	203.81	4,422.60	3,143.76	314.38	3,685.50	3,880.86	388.09
Employee Only	Family	Family	5,896.80	2,496.96	249.70	5,528.25	2,865.51	286.55	4,422.60	3,971.16	397.12	3,685.50	4,708.26	470.83
Employee+1 Dependent	Emp	Emp	10,179.20	1,019.92	101.99	9,543.00	1,656.12	165.61	7,634.40	3,564.72	356.47	6,362.00	4,837.12	483.71
Employee+1 Dependent	Emp+1	Emp+1	10,179.20	1,732.96	173.30	9,543.00	2,369.16	236.92	7,634.40	4,277.76	427.78	6,362.00	5,550.16	555.02
Employee+1 Dependent	Family	Family	10,179.20	2,560.36	256.04	9,543.00	3,196.56	319.66	7,634.40	5,105.16	510.52	6,362.00	6,377.56	637.76
Family Coverage	Emp	Emp	13,186.40	743.08	74.31	12,362.25	1,567.23	156.72	9,889.80	4,039.68	403.97	8,241.50	5,687.98	568.80
Family Coverage	Emp+1	Emp+1	13,186.40	1,456.12	145.61	12,362.25	2,280.27	228.03	9,889.80	4,752.72	475.27	8,241.50	6,401.02	640.10
Family Coverage	Family	Family	13,186.40	2,283.52	228.35	12,362.25	3,107.67	310.77	9,889.80	5,580.12	558.01	8,241.50	7,228.42	722.84

NOTES:

Benefits Cap: The District benefits cap allocation for 2015-2016 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 $7,371 for employee-only medical coverage, $12,724 for employee plus one dependent, $16,483 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.