CALIFORNIA'S VALUED TRUST (CVT) PPO PLAN OPTIONS

Plan Year: October 1, 2024 - September 30, 2025

CERTIFICATED

Updated: 5.13.24

MEDICAL PLAN OPTIONS								
MONTHLY PREMIUM (Medical & Prescription)		**1A**	**4A**	**WELLNESS**	**8A**	**10D**	**HDHP-3**	**BRONZE**
		$2,529	**$2,244**	**$2,082**	**$1,871**	**$1,344**	**$1,048**	**$1,138**
CALENDAR YEAR DEDUCTIBLE	Per Individual	$0	$100	$500	$500	$2,000	$6,500	$5,000
	Per Family	$0	$200	$1,000	$1,000	$4,000	$13,000	$10,000
COPAY	Your cost after deductible is met	0%	10%	10%	20%	20%	30%	30%
CALENDAR YEAR OUT - OF - POCKET MAXIMUM	Per Individual	$1,250	$1,250	$1,750	$3,250	$6,350	$8,000	$7,000
	Per Family	$2,500	$2,500	$3,500	$6,500	$12,700	$16,000	$14,000
	Per individual in a family	$1,250	$1,250	$1,750	$3,250	$6,350	$8,000	$7,000
OFFICE VISIT COPAY		$10	$20	$20 Primary $40 Specialty	$30	Paid at 80% after deductible is met	$60 Primary $90 Specialty after deductible is met	$60 up to 3 visits/ Pd at 70% after deductilbe is met
MD LIVE COPAY		$0	$0	$0	$0	$0	Paid after deductibe is met	$0

PRESCRIPTION PLAN NAME	A	WELLNESS	D	HDHP-3 & BRONZE
Prescription plans are paired with a medical plan as listed above. Example: 1A Medical Plan includes the 'A' Prescription Plan	**Retail (30 day supply):** $5 Generic $22 Brand Name **Mail Order (90 day supply):** $10 Generic $44 Brand Name	**Retail (30 day supply):** $7 Generic $25 Preferred Brand Name $40 Non-Preferred Brand **Mail Order (90 day supply):** $15 Generic $60 Preferred Brand Name $90 Non-Prefered Brand	**Retail (30 day supply):** $10 Generic $40 Brand Preferred $100 Brand Non-Preferred **Mail Order (90 day supply):** $25 Generic $100 Brand Preferred $250 Brand Non-Preferred	**Retail (30 day supply):** **Paid after deductible is met** $25 Generic $50 Brand Name **Mail Order (90 day supply):** $50 Generic $100 Brand Preferred

DISTRICT & EMPLOYEE COST	PLAN CHOICES	1A	4A	WELLNESS	8A	10D	HDHP-3	BRONZE
Misc. Information: *Certificated employees pay insurance premiums one month in* ***advance****: Example-Premium paid in August is for September coverage.* *Monthly premium cost is calculated for 12 months of insurance. Employee monthly premium contributions are averaged annually and deducted in each end of month pay check.* ***District Paid Monthly Cap*** *10* *month employee: $1100.48* *11 month employee: $1000.44* *12 month employee: $917.07* *Employee cost will differ from listed monthly prices for late starts and year hires*	Medical/Prescription	$2,529.00	$2,244.00	$2,082.00	$1,871.00	$1,344.00	$1,048.00	$1,138.00
	Vision B $15 Copay	$16.18	$16.18	$16.18	$16.18	$16.18	$16.18	$16.18
	Dental Unlimited Annual	$121.70	$121.70	$121.70	$121.70	$121.70	$121.70	$121.70
	Total Monthly Package Cost	$2,666.88	$2,381.88	$2,219.88	$2,008.88	$1,481.88	$1,185.88	$1,275.88
	Total Annual Package Cost	$32,002.56	$28,582.56	$26,638.56	$24,106.56	$17,782.56	$14,230.56	$15,310.56
	Less Annual District Paid CAP	***($11,004.80)***	***($11,004.80)***	***($11,004.80)***	***($11,004.80)***	***($11,004.80)***	***($11,004.80)***	***($11,004.80)***
	Total Annual Cost to Employee	*$20,997.76*	*$17,577.76*	*$15,633.76*	*$13,101.76*	*$6,777.76*	*$3,225.76*	*$4,305.76*
	10 Month Employee Cost (Contract Aug-May)	**$2,099.78**	**$1,757.78**	**$1,563.38**	**$1,310.18**	**$677.78**	**$322.58**	**$430.58**
	12 Month Employee Cost (Contract July-June)	**$1,749.81**	**$1,464.81**	**$1,302.81**	**$1,091.81**	**$564.81**	**$268.81**	**$358.81**