2016-17 BENEFIT RATE SHEET - CSEA

Full time (8 hour) Employee

		MONTHLY RATES				MONTHLY COST		
Plan	**Type**	**Medical**	**Dental***	**Vision**	**Life**	**Benefit Total Cost**	***ER Contribution (CAP)****	**EE Total Contribution**
Bronze	EE	$387	$57.80	$7.76	$6.30	$458.86	*$478.00*	$0.00
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$924.00*	$0.00
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$1,255.00*	$0.00
HDHP-3	EE	$387	$57.80	$7.76	$6.30	$458.86	*$478.00*	$0.00
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$924.00*	$0.00
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$1,255.00*	$0.00
PPO-10B	EE	$487	$57.80	$7.76	$6.30	$558.86	*$478.00*	$80.86
	EE+1	$974	$104.59	$14.70	$6.30	$1,099.59	*$924.00*	$175.59
	EE + Family	$1,311	$150.41	$22.89	$6.30	$1,490.60	*$1,255.00*	$235.60
PPO-9B	EE	$558	$57.80	$7.76	$6.30	$629.86	*$478.00*	$151.86
	EE+1	$1,116	$104.59	$14.70	$6.30	$1,241.59	*$924.00*	$317.59
	EE + Family	$1,502	$150.41	$22.89	$6.30	$1,681.60	*$1,255.00*	$426.60
PPO-8B	EE	$622	$57.80	$7.76	$6.30	$693.86	*$478.00*	$215.86
	EE+1	$1,244	$104.59	$14.70	$6.30	$1,369.59	*$924.00*	$445.59
	EE + Family	$1,674	$150.41	$22.89	$6.30	$1,853.60	*$1,255.00*	$598.60
WELL-1C	EE	$690	$57.80	$7.76	$6.30	$761.86	*$478.00*	$283.86
	EE+1	$1,380	$104.59	$14.70	$6.30	$1,505.59	*$924.00*	$581.59
	EE + Family	$1,857	$150.41	$22.89	$6.30	$2,036.60	*$1,255.00*	$781.60
PPO-4A	EE	$742	$57.80	$7.76	$6.30	$813.86	*$478.00*	$335.86
	EE+1	$1,484	$104.59	$14.70	$6.30	$1,609.59	*$924.00*	$685.59
	EE + Family	$1,996	$150.41	$22.89	$6.30	$2,175.60	*$1,255.00*	$920.60

TCDE definition: full-time employment is 8 hours per day, 260 days per year. Employees in positions less than full time will receive a prorated contribution. If you work less than full-time, please contact Lourie in Payroll @ 530-528-5335 or llarcade@tehamaschools.org to obtain information regarding actuals costs

**ER Contribution is based on full-time employment.*

***Dental - max $1,500; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - CSEA

7 hour per day Employee

		MONTHLY RATES				MONTHLY COST		
Plan	**Type**	**Medical**	**Dental***	**Vision**	**Life**	**Benefit Total Cost**	***ER Contribution (CAP)****	**EE Total Contribution**
Bronze	EE	$387	$57.80	$7.76	$6.30	$458.86	*$418.25*	$0.00
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$808.50*	$0.00
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$1,098.13*	$0.00
HDHP-3	EE	$387	$57.80	$7.76	$6.30	$458.86	*$418.25*	$0.00
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$808.50*	$0.00
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$1,098.13*	$0.00
PPO-10B	EE	$487	$57.80	$7.76	$6.30	$558.86	*$418.25*	$140.61
	EE+1	$974	$104.59	$14.70	$6.30	$1,099.59	*$808.50*	$291.09
	EE + Family	$1,311	$150.41	$22.89	$6.30	$1,490.60	*$1,098.13*	$392.47
PPO-9B	EE	$558	$57.80	$7.76	$6.30	$629.86	*$418.25*	$211.61
	EE+1	$1,116	$104.59	$14.70	$6.30	$1,241.59	*$808.50*	$433.09
	EE + Family	$1,502	$150.41	$22.89	$6.30	$1,681.60	*$1,098.13*	$583.47
PPO-8B	EE	$622	$57.80	$7.76	$6.30	$693.86	*$418.25*	$275.61
	EE+1	$1,244	$104.59	$14.70	$6.30	$1,369.59	*$808.50*	$561.09
	EE + Family	$1,674	$150.41	$22.89	$6.30	$1,853.60	*$1,098.13*	$755.47
WELL-1C	EE	$690	$57.80	$7.76	$6.30	$761.86	*$418.25*	$343.61
	EE+1	$1,380	$104.59	$14.70	$6.30	$1,505.59	*$808.50*	$697.09
	EE + Family	$1,857	$150.41	$22.89	$6.30	$2,036.60	*$1,098.13*	$938.47
PPO-4A	EE	$742	$57.80	$7.76	$6.30	$813.86	*$418.25*	$395.61
	EE+1	$1,484	$104.59	$14.70	$6.30	$1,609.59	*$808.50*	$801.09
	EE + Family	$1,996	$150.41	$22.89	$6.30	$2,175.60	*$1,098.13*	$1,077.47

TCDE definition: full-time employment is 8 hours per day, 260 days per year. Employees in positions less than full time will receive a prorated contribution. If you work less than full-time, please contact Lourie in Payroll @ 530-528-5335 or llarcade@tehamaschools.org to obtain information regarding actuals costs

**ER Contribution is based on full-time employment.*

***Dental - max $1,500; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - CSEA

6 hour per day Employee

		MONTHLY RATES				MONTHLY COST		
Plan	**Type**	**Medical**	**Dental***	**Vision**	**Life**	**Benefit Total Cost**	***ER Contribution (CAP)****	**EE Total Contribution**
Bronze	EE	$387	$57.80	$7.76	$6.30	$458.86	*$358.50*	$100.36
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$693.00*	$206.59
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$941.25*	$280.35
HDHP-3	EE	$387	$57.80	$7.76	$6.30	$458.86	*$358.50*	$100.36
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$693.00*	$206.59
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$941.25*	$280.35
PPO-10B	EE	$487	$57.80	$7.76	$6.30	$558.86	*$358.50*	$200.36
	EE+1	$974	$104.59	$14.70	$6.30	$1,099.59	*$693.00*	$406.59
	EE + Family	$1,311	$150.41	$22.89	$6.30	$1,490.60	*$941.25*	$549.35
PPO-9B	EE	$558	$57.80	$7.76	$6.30	$629.86	*$358.50*	$271.36
	EE+1	$1,116	$104.59	$14.70	$6.30	$1,241.59	*$693.00*	$548.59
	EE + Family	$1,502	$150.41	$22.89	$6.30	$1,681.60	*$941.25*	$740.35
PPO-8B	EE	$622	$57.80	$7.76	$6.30	$693.86	*$358.50*	$335.36
	EE+1	$1,244	$104.59	$14.70	$6.30	$1,369.59	*$693.00*	$676.59
	EE + Family	$1,674	$150.41	$22.89	$6.30	$1,853.60	*$941.25*	$912.35
WELL-1C	EE	$690	$57.80	$7.76	$6.30	$761.86	*$358.50*	$403.36
	EE+1	$1,380	$104.59	$14.70	$6.30	$1,505.59	*$693.00*	$812.59
	EE + Family	$1,857	$150.41	$22.89	$6.30	$2,036.60	*$941.25*	$1,095.35
PPO-4A	EE	$742	$57.80	$7.76	$6.30	$813.86	*$358.50*	$455.36
	EE+1	$1,484	$104.59	$14.70	$6.30	$1,609.59	*$693.00*	$916.59
	EE + Family	$1,996	$150.41	$22.89	$6.30	$2,175.60	*$941.25*	$1,234.35

TCDE definition: full-time employment is 8 hours per day, 260 days per year. Employees in positions less than full time will receive a prorated contribution. If you work less than full-time, please contact Lourie in Payroll @ 530-528-5335 or llarcade@tehamaschools.org to obtain information regarding actuals costs

**ER Contribution is based on full-time employment.*

***Dental - max $1,500; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - CSEA
5 hour per day Employee

		MONTHLY RATES				MONTHLY COST		
Plan	**Type**	**Medical**	**Dental***	**Vision**	**Life**	**Benefit Total Cost**	***ER Contribution (CAP)****	**EE Total Contribution**
Bronze	EE	$387	$57.80	$7.76	$6.30	$458.86	*$298.75*	$160.11
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$577.50*	$322.09
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$784.38*	$437.22
HDHP-3	EE	$387	$57.80	$7.76	$6.30	$458.86	*$298.75*	$160.11
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$577.50*	$322.09
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$784.38*	$437.22
PPO-10B	EE	$487	$57.80	$7.76	$6.30	$558.86	*$298.75*	$260.11
	EE+1	$974	$104.59	$14.70	$6.30	$1,099.59	*$577.50*	$522.09
	EE + Family	$1,311	$150.41	$22.89	$6.30	$1,490.60	*$784.38*	$706.22
PPO-9B	EE	$558	$57.80	$7.76	$6.30	$629.86	*$298.75*	$331.11
	EE+1	$1,116	$104.59	$14.70	$6.30	$1,241.59	*$577.50*	$664.09
	EE + Family	$1,502	$150.41	$22.89	$6.30	$1,681.60	*$784.38*	$897.22
PPO-8B	EE	$622	$57.80	$7.76	$6.30	$693.86	*$298.75*	$395.11
	EE+1	$1,244	$104.59	$14.70	$6.30	$1,369.59	*$577.50*	$792.09
	EE + Family	$1,674	$150.41	$22.89	$6.30	$1,853.60	*$784.38*	$1,069.22
WELL-1C	EE	$690	$57.80	$7.76	$6.30	$761.86	*$298.75*	$463.11
	EE+1	$1,380	$104.59	$14.70	$6.30	$1,505.59	*$577.50*	$928.09
	EE + Family	$1,857	$150.41	$22.89	$6.30	$2,036.60	*$784.38*	$1,252.22
PPO-4A	EE	$742	$57.80	$7.76	$6.30	$813.86	*$298.75*	$515.11
	EE+1	$1,484	$104.59	$14.70	$6.30	$1,609.59	*$577.50*	$1,032.09
	EE + Family	$1,996	$150.41	$22.89	$6.30	$2,175.60	*$784.38*	$1,391.22

TCDE definition: full-time employment is 8 hours per day, 260 days per year. Employees in positions less than full time will receive a prorated contribution. If you work less than full-time, please contact Lourie in Payroll @ 530-528-5335 or llarcade@tehamaschools.org to obtain information regarding actuals costs

**ER Contribution is based on full-time employment.*

***Dental - max $1,500; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - CSEA

4 hour per day Employee

		MONTHLY RATES				MONTHLY COST		
Plan	**Type**	**Medical**	**Dental***	**Vision**	**Life**	**Benefit Total Cost**	***ER Contribution (CAP)****	**EE Total Contribution**
Bronze	EE	$387	$57.80	$7.76	$6.30	$458.86	*$239.00*	$219.86
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$462.00*	$437.59
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$627.50*	$594.10
HDHP-3	EE	$387	$57.80	$7.76	$6.30	$458.86	*$239.00*	$219.86
	EE+1	$774	$104.59	$14.70	$6.30	$899.59	*$462.00*	$437.59
	EE + Family	$1,042	$150.41	$22.89	$6.30	$1,221.60	*$627.50*	$594.10
PPO-10B	EE	$487	$57.80	$7.76	$6.30	$558.86	*$239.00*	$319.86
	EE+1	$974	$104.59	$14.70	$6.30	$1,099.59	*$462.00*	$637.59
	EE + Family	$1,311	$150.41	$22.89	$6.30	$1,490.60	*$627.50*	$863.10
PPO-9B	EE	$558	$57.80	$7.76	$6.30	$629.86	*$239.00*	$390.86
	EE+1	$1,116	$104.59	$14.70	$6.30	$1,241.59	*$462.00*	$779.59
	EE + Family	$1,502	$150.41	$22.89	$6.30	$1,681.60	*$627.50*	$1,054.10
PPO-8B	EE	$622	$57.80	$7.76	$6.30	$693.86	*$239.00*	$454.86
	EE+1	$1,244	$104.59	$14.70	$6.30	$1,369.59	*$462.00*	$907.59
	EE + Family	$1,674	$150.41	$22.89	$6.30	$1,853.60	*$627.50*	$1,226.10
WELL-1C	EE	$690	$57.80	$7.76	$6.30	$761.86	*$239.00*	$522.86
	EE+1	$1,380	$104.59	$14.70	$6.30	$1,505.59	*$462.00*	$1,043.59
	EE + Family	$1,857	$150.41	$22.89	$6.30	$2,036.60	*$627.50*	$1,409.10
PPO-4A	EE	$742	$57.80	$7.76	$6.30	$813.86	*$239.00*	$574.86
	EE+1	$1,484	$104.59	$14.70	$6.30	$1,609.59	*$462.00*	$1,147.59
	EE + Family	$1,996	$150.41	$22.89	$6.30	$2,175.60	*$627.50*	$1,548.10

TCDE definition: full-time employment is 8 hours per day, 260 days per year. Employees in positions less than full time will receive a prorated contribution. If you work less than full-time, please contact Lourie in Payroll @ 530-528-5335 or llarcade@tehamaschools.org to obtain information regarding actuals costs

**ER Contribution is based on full-time employment.*

***Dental - max $1,500; Nitros Oxide*

CVT PPO Health Plans

Tehama County DOE - CLASSIFIED

October 1, 2016 - September 30, 2017

BENEFIT	PPO 4A	PPO 8B	PPO 9B	PPO 10B
Calendar Year Deductible	Individual: $100 Family: $300	Individual: $500 Family: $1,500	Individual: $1,000 Family: $3,000	Individual: $2,000 Family: $6,000
Coinsurance	Paid at 90%* after deductible is met	Paid at 80%* 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 deductible, coinsurance, medical and pharmacy copays)	Individual: $1,250(2) Family: $3,750(2)	Individual: $3,250(2) Family: $9,750(2)	Individual: $5,000(2) Family: $10,000(2)	Individual: $6,350(2) Family: $12,700(2)
Doctor Visits (Primary Care Physician)	$20 Copay	$30 Copay	$35 Copay	Paid at 80%* after deductible is met
Doctor Visits (Specialty Physician)	$20 Copay	$30 Copay	$35 Copay	Paid at 80%* after deductible is met
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Diagnostic Test / Imaging	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Radiation Therapy, Chemotherapy	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Ambulance - Ground / Air	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Physical Therapy	Paid at 90%*(1) after deductible is met (Copay, if applicable.)	Paid at 80%*(1) after deductible is met (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 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.)	Paid at 80%*(1) after deductible is met (Copay, if applicable.)
Acupuncture	Paid at 90%* after deductible is met (Copay, if applicable) Maximum of 12 visits per calendar year	Paid at 80%* after deductible is met (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	Paid at 90%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met	Paid at 80%* after deductible is met
Hospital Inpatient	Paid at 90%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)	Paid at 80%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)	Paid at 80%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)	Paid at 80%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)
Hospital Emergency Room	$100 Copay (Copay waived if admitted as inpatient) Paid at 90%* after deductible is met	$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met	$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met	$100 Copay (Copay waived if admitted as inpatient) Paid at 80%* after deductible is met
Urgent Care	$20 Copay	$30 Copay	$35 Copay	Paid at 80%* after deductible is met
Home Health Care	Paid at 90%* after deductible is met; Limited to 100 visits per calendar year	Paid at 80%* after deductible is met Limited to 100 visits per calendar year	Paid at 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
Telemedicine	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.

BENEFIT	PPO 4A		PPO 8B		PPO 9B		PPO 10B	
Employee Assistance Program (EAP) through Beacon Health Options	Paid at 100% - Visit **www. achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)		Paid at 100% - Visit **www. achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)		Paid at 100% - Visit **www. achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)		Paid at 100% - Visit **www. achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)	
Prescription Drugs	**Retail** $5 Generic $22 Brand (30-Day Supply)	**Mail Order** $10 Generic $44 Brand (90-Day Supply)	**Retail** $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order** $15 Generic $35 Preferred $70 Non-Preferred (90-Day Supply)	**Retail** $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order** $15 Generic $35 Preferred $70 Non-Preferred (90-Day Supply)	**Retail** $7 Generic $15 Preferred $30 Non-Preferred (30-Day Supply)	**Mail Order** $15 Generic $35 Preferred $70 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.

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

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

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

(4)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

CVT PPO Health Plans

Tehama County DOE - CLASSIFIED

October 1, 2016 - September 30, 2017

BENEFIT	PPO Wellness	HDHP 3	PPO Bronze
Calendar Year Deductible	Individual: $500 Family: $1,000	Individual: $1,300 Family: $5,000 (No individual limit applies to family)	Individual: $5,000 Family: $10,000
Coinsurance	Paid at 90%* after deductible is met	Paid at 60%* after deductible is met	Paid at 70%* after deductible is met
Calendar Year Out of Pocket Maximum (includes deductible, coinsurance, medical and pharmacy copays)	Individual: $1,750(2) Family: $5,250(2)	Individual: $6,250(2) Family: $12,500(2) Family = Employee with one or more covered dependents. No one individual will pay more than $6,850.	Individual: $6,350(2) Family: $12,700(2)
Doctor Visits (Primary Care Physician)	$20 Copay	Paid at 60%* after deductible is met	First 3 visits covered in full after $60 Copay per visit; Remaining visits - Paid at 70%* after deductible is met
Doctor Visits (Specialty Physician)	$40 Copay	Paid at 60%* after deductible is met	Subject to deductible then $70 copay
Preventive Care / Immunizations	Paid at 100%*	Paid at 100%*	Paid at 100%*
Outpatient Diagnostic Test / Imaging	Paid at 90%* after deductible is met	Paid at 60%* after deductible is met	Paid at 70%* after deductible is met
Radiation Therapy, Chemotherapy	Paid at 90%* after deductible is met	Paid at 60%* after deductible is met	Paid at 70%* after deductible is met
Durable Medical Equipment	Paid at 90%* after deductible is met	Paid at 60%* after deductible is met	Paid at 70%* after deductible is met
Ambulance - Ground / Air	Paid at 90%* after deductible is met	Paid at 60%* 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 60%*(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 60%*(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 60%* 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	Paid at 90%* after deductible is met	Paid at 60%* 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 **(RBB price cap)**(3)	Paid at 60%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)	Paid at 70%* after deductible is met; Unlimited days, Semi-private room **(RBB price cap)**(3)
Hospital Emergency Room	$100 Copay (Copay waived if admitted as inpatient) Paid at 90%* after deductible is met	Paid at 60%* after deductible is met	Subject to Deductible, then $250 Copay (copay waived if admitted as in-patient)
Urgent Care	$20 Copay	Paid at 60%* 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 60%* after deductible is met; Limited to 100 visits per calendar year	Paid at 70%* after deductible is met; Limited to 100 visits per calendar year

BENEFIT	PPO Wellness		HDHP 3	PPO Bronze	
Telemedicine	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.		MDLIVE - Paid at 60%* after deductible is met Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	MDLIVE - $5 Copay Call 1-888-632-2738 or visit mdlive.com/CVT for non-emergency medical conditions.	
Employee Assistance Program (EAP) through Beacon Health Options	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)		Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)	Paid at 100% - Visit **www.achievesolutions.net/cvt** or call **1-877-397-1032** to access benefit(4)	
Prescription Drugs	**Retail** $7 Generic $25 Pref $40 Non-Pref (30-Day Supply)	**Mail Order** $15 Generic $60 Pref $90 Non-Pref (90-Day Supply)	Paid at 60%* after deductible is met	**Retail** Subject to deductible, then $25 copay generic $50 copay brand (30-Day Supply)	**Mail Order** Subject to deductible, then $50 copay generic $100 copay brand (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.

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

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

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

(4)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