2016-17 BENEFIT RATE SHEET - UNREPRESENTED

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	$62.82	$9.05	$18.75	$477.62	*$478.00*	$0.00
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$924.00*	$0.00
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$1,255.00*	$0.00
HDHP-3	EE	$387	$62.82	$9.05	$18.75	$477.62	*$478.00*	$0.00
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$924.00*	$0.00
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$1,255.00*	$0.00
PPO-9A	EE	$562	$62.82	$9.05	$18.75	$652.62	*$478.00*	$174.62
	EE+1	$1,124	$113.73	$16.87	$18.75	$1,273.35	*$924.00*	$349.35
	EE + Family	$1,512	$163.53	$25.06	$18.75	$1,719.34	*$1,255.00*	$464.34
PPO-8C	EE	$612	$62.82	$9.05	$18.75	$702.62	*$478.00*	$224.62
	EE+1	$1,224	$113.73	$16.87	$18.75	$1,373.35	*$924.00*	$449.35
	EE + Family	$1,647	$163.53	$25.06	$18.75	$1,854.34	*$1,255.00*	$599.34
PPO-6A	EE	$687	$62.82	$9.05	$18.75	$777.62	*$478.00*	$299.62
	EE+1	$1,374	$113.73	$16.87	$18.75	$1,523.35	*$924.00*	$599.35
	EE + Family	$1,849	$163.53	$25.06	$18.75	$2,056.34	*$1,255.00*	$801.34
WELL-1C	EE	$690	$62.82	$9.05	$18.75	$780.62	*$478.00*	$302.62
	EE+1	$1,380	$113.73	$16.87	$18.75	$1,529.35	*$924.00*	$605.35
	EE + Family	$1,857	$163.53	$25.06	$18.75	$2,064.34	*$1,255.00*	$809.34
PPO-4A	EE	$742	$62.82	$9.05	$18.75	$832.62	*$478.00*	$354.62
	EE+1	$1,484	$113.73	$16.87	$18.75	$1,633.35	*$924.00*	$709.35
	EE + Family	$1,996	$163.53	$25.06	$18.75	$2,203.34	*$1,255.00*	$948.34

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 $2,000; Prosthodontics 70/30; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - UNREPRESENTED

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	$62.82	$9.05	$18.75	$477.62	*$418.25*	$59.37
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$808.50*	$114.85
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$1,098.13*	$151.21
HDHP-3	EE	$387	$62.82	$9.05	$18.75	$477.62	*$418.25*	$59.37
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$808.50*	$114.85
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$1,098.13*	$151.21
PPO-9A	EE	$562	$62.82	$9.05	$18.75	$652.62	*$418.25*	$234.37
	EE+1	$1,124	$113.73	$16.87	$18.75	$1,273.35	*$808.50*	$464.85
	EE + Family	$1,512	$163.53	$25.06	$18.75	$1,719.34	*$1,098.13*	$621.21
PPO-8C	EE	$612	$62.82	$9.05	$18.75	$702.62	*$418.25*	$284.37
	EE+1	$1,224	$113.73	$16.87	$18.75	$1,373.35	*$808.50*	$564.85
	EE + Family	$1,647	$163.53	$25.06	$18.75	$1,854.34	*$1,098.13*	$756.21
PPO-6A	EE	$687	$62.82	$9.05	$18.75	$777.62	*$418.25*	$359.37
	EE+1	$1,374	$113.73	$16.87	$18.75	$1,523.35	*$808.50*	$714.85
	EE + Family	$1,849	$163.53	$25.06	$18.75	$2,056.34	*$1,098.13*	$958.21
WELL-1C	EE	$690	$62.82	$9.05	$18.75	$780.62	*$418.25*	$362.37
	EE+1	$1,380	$113.73	$16.87	$18.75	$1,529.35	*$808.50*	$720.85
	EE + Family	$1,857	$163.53	$25.06	$18.75	$2,064.34	*$1,098.13*	$966.21
PPO-4A	EE	$742	$62.82	$9.05	$18.75	$832.62	*$418.25*	$414.37
	EE+1	$1,484	$113.73	$16.87	$18.75	$1,633.35	*$808.50*	$824.85
	EE + Family	$1,996	$163.53	$25.06	$18.75	$2,203.34	*$1,098.13*	$1,105.21

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 $2,000; Prosthodontics 70/30; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - UNREPRESENTED

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	$62.82	$9.05	$18.75	$477.62	*$358.50*	$119.12
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$693.00*	$230.35
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$941.25*	$308.09
HDHP-3	EE	$387	$62.82	$9.05	$18.75	$477.62	*$358.50*	$119.12
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$693.00*	$230.35
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$941.25*	$308.09
PPO-9A	EE	$562	$62.82	$9.05	$18.75	$652.62	*$358.50*	$294.12
	EE+1	$1,124	$113.73	$16.87	$18.75	$1,273.35	*$693.00*	$580.35
	EE + Family	$1,512	$163.53	$25.06	$18.75	$1,719.34	*$941.25*	$778.09
PPO-8C	EE	$612	$62.82	$9.05	$18.75	$702.62	*$358.50*	$344.12
	EE+1	$1,224	$113.73	$16.87	$18.75	$1,373.35	*$693.00*	$680.35
	EE + Family	$1,647	$163.53	$25.06	$18.75	$1,854.34	*$941.25*	$913.09
PPO-6A	EE	$687	$62.82	$9.05	$18.75	$777.62	*$358.50*	$419.12
	EE+1	$1,374	$113.73	$16.87	$18.75	$1,523.35	*$693.00*	$830.35
	EE + Family	$1,849	$163.53	$25.06	$18.75	$2,056.34	*$941.25*	$1,115.09
WELL-1C	EE	$690	$62.82	$9.05	$18.75	$780.62	*$358.50*	$422.12
	EE+1	$1,380	$113.73	$16.87	$18.75	$1,529.35	*$693.00*	$836.35
	EE + Family	$1,857	$163.53	$25.06	$18.75	$2,064.34	*$941.25*	$1,123.09
PPO-4A	EE	$742	$62.82	$9.05	$18.75	$832.62	*$358.50*	$474.12
	EE+1	$1,484	$113.73	$16.87	$18.75	$1,633.35	*$693.00*	$940.35
	EE + Family	$1,996	$163.53	$25.06	$18.75	$2,203.34	*$941.25*	$1,262.09

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 $2,000; Prosthodontics 70/30; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - UNREPRESENTED

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	$62.82	$9.05	$18.75	$477.62	*$298.75*	$178.87
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$577.50*	$345.85
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$784.38*	$464.96
HDHP-3	EE	$387	$62.82	$9.05	$18.75	$477.62	*$298.75*	$178.87
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$577.50*	$345.85
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$784.38*	$464.96
PPO-9A	EE	$562	$62.82	$9.05	$18.75	$652.62	*$298.75*	$353.87
	EE+1	$1,124	$113.73	$16.87	$18.75	$1,273.35	*$577.50*	$695.85
	EE + Family	$1,512	$163.53	$25.06	$18.75	$1,719.34	*$784.38*	$934.96
PPO-8C	EE	$612	$62.82	$9.05	$18.75	$702.62	*$298.75*	$403.87
	EE+1	$1,224	$113.73	$16.87	$18.75	$1,373.35	*$577.50*	$795.85
	EE + Family	$1,647	$163.53	$25.06	$18.75	$1,854.34	*$784.38*	$1,069.96
PPO-6A	EE	$687	$62.82	$9.05	$18.75	$777.62	*$298.75*	$478.87
	EE+1	$1,374	$113.73	$16.87	$18.75	$1,523.35	*$577.50*	$945.85
	EE + Family	$1,849	$163.53	$25.06	$18.75	$2,056.34	*$784.38*	$1,271.96
WELL-1C	EE	$690	$62.82	$9.05	$18.75	$780.62	*$298.75*	$481.87
	EE+1	$1,380	$113.73	$16.87	$18.75	$1,529.35	*$577.50*	$951.85
	EE + Family	$1,857	$163.53	$25.06	$18.75	$2,064.34	*$784.38*	$1,279.96
PPO-4A	EE	$742	$62.82	$9.05	$18.75	$832.62	*$298.75*	$533.87
	EE+1	$1,484	$113.73	$16.87	$18.75	$1,633.35	*$577.50*	$1,055.85
	EE + Family	$1,996	$163.53	$25.06	$18.75	$2,203.34	*$784.38*	$1,418.96

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 $2,000; Prosthodontics 70/30; Nitros Oxide*

2016-17 BENEFIT RATE SHEET - UNREPRESENTED

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	$62.82	$9.05	$18.75	$477.62	*$239.00*	$238.62
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$462.00*	$461.35
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$627.50*	$621.84
HDHP-3	EE	$387	$62.82	$9.05	$18.75	$477.62	*$239.00*	$238.62
	EE+1	$774	$113.73	$16.87	$18.75	$923.35	*$462.00*	$461.35
	EE + Family	$1,042	$163.53	$25.06	$18.75	$1,249.34	*$627.50*	$621.84
PPO-9A	EE	$562	$62.82	$9.05	$18.75	$652.62	*$239.00*	$413.62
	EE+1	$1,124	$113.73	$16.87	$18.75	$1,273.35	*$462.00*	$811.35
	EE + Family	$1,512	$163.53	$25.06	$18.75	$1,719.34	*$627.50*	$1,091.84
PPO-8C	EE	$612	$62.82	$9.05	$18.75	$702.62	*$239.00*	$463.62
	EE+1	$1,224	$113.73	$16.87	$18.75	$1,373.35	*$462.00*	$911.35
	EE + Family	$1,647	$163.53	$25.06	$18.75	$1,854.34	*$627.50*	$1,226.84
PPO-6A	EE	$687	$62.82	$9.05	$18.75	$777.62	*$239.00*	$538.62
	EE+1	$1,374	$113.73	$16.87	$18.75	$1,523.35	*$462.00*	$1,061.35
	EE + Family	$1,849	$163.53	$25.06	$18.75	$2,056.34	*$627.50*	$1,428.84
WELL-1C	EE	$690	$62.82	$9.05	$18.75	$780.62	*$239.00*	$541.62
	EE+1	$1,380	$113.73	$16.87	$18.75	$1,529.35	*$462.00*	$1,067.35
	EE + Family	$1,857	$163.53	$25.06	$18.75	$2,064.34	*$627.50*	$1,436.84
PPO-4A	EE	$742	$62.82	$9.05	$18.75	$832.62	*$239.00*	$593.62
	EE+1	$1,484	$113.73	$16.87	$18.75	$1,633.35	*$462.00*	$1,171.35
	EE + Family	$1,996	$163.53	$25.06	$18.75	$2,203.34	*$627.50*	$1,575.84

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 $2,000; Prosthodontics 70/30; Nitros Oxide*

CVT PPO Health Plans

Tehama County DOE - M/C OTHER

October 1, 2016 - September 30, 2017

BENEFIT	PPO 4A	PPO 6A	PPO 8C	PPO 9A
Calendar Year Deductible	Individual: $100 Family: $300	Individual: $250 Family: $750	Individual: $500 Family: $1,500	Individual: $1,000 Family: $3,000
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: $2,000(2) Family: $6,000(2)	Individual: $3,250(2) Family: $9,750(2)	Individual: $5,000(2) Family: $10,000(2)
Doctor Visits (Primary Care Physician)	$20 Copay	$20 Copay	$30 Copay	$35 Copay
Doctor Visits (Specialty Physician)	$20 Copay	$20 Copay	$30 Copay	$35 Copay
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	$20 Copay	$30 Copay	$35 Copay
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 6A	PPO 8C	PPO 9A
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** $5 Generic $22 Brand (30-Day Supply) **Mail Order** $10 Generic $44 Brand (90-Day Supply)	**Retail** $7 Generic $25 Pref $40 Non-Pref (30-Day Supply) **Mail Order** $15 Generic $60 Pref $90 Non-Pref (90-Day Supply)	**Retail** $5 Generic $22 Brand (30-Day Supply) **Mail Order** $10 Generic $44 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

CVT PPO Health Plans

Tehama County DOE - M/C OTHER

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