CALIFORNIA'S VALUED TRUST (CVT) PPO PLAN OPTIONS

Plan Year: October 1, 2025 - September 30, 2026

CERTIFICATED

Updated: 9/30/2025

MEDICAL PLAN OPTIONS								
MONTHLY PREMIUM (Medical & Prescription)		**1A**	**4A**	**WELLNESS**	**8A**	**10D**	**BRONZE**	**HDHP-3**
		$2,954	**$2,621**	**$2,433**	**$2,185**	**$1,571**	**$1,329**	**$1,224**
CALENDAR YEAR DEDUCTIBLE	Per Individual	$0	$100	$500	$500	$2,000	$5,000	$6,500
	Per Family	$0	$200	$1,000	$1,000	$4,000	$10,000	$13,000
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	$7,000	$8,000
	Per Family	$2,500	$2,500	$3,500	$6,500	$12,700	$14,000	$16,000
	Per individual in a family	$1,250	$1,250	$1,750	$3,250	$6,350	$7,000	$8,000
OFFICE VISIT COPAY		$10	$20	$20 Primary $40 Specialty	$30	Paid at 80% after deductible is met	$60 up to 3 visits/ Pd at 70% after deductilbe is met	$60 Primary $90 Specialty after deductible is met
MD LIVE COPAY		$0	$0	$0	$0	$0	$0	Paid after deductibe is met

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 $150 Brand Deductible **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	BRONZE	HDHP-3
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	$2,954.00	$2,621.00	$2,433.00	$2,185.00	$1,571.00	$1,329.00	$1,224.00
	Vision C $15 Copay	$24.29	$24.29	$24.29	$24.29	$24.29	$24.29	$24.29
	Dental Unlimited Annual	$127.79	$127.79	$127.79	$127.79	$127.79	$127.79	$127.79
	Total Monthly Package Cost	$3,106.08	$2,773.08	$2,585.08	$2,337.08	$1,723.08	$1,481.08	$1,376.08
	Total Annual Package Cost	$37,272.96	$33,276.96	$31,020.96	$28,044.96	$20,676.96	$17,772.96	$16,512.96
	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	*$26,268.16*	*$22,272.16*	*$20,016.16*	*$17,040.16*	*$9,672.16*	*$6,768.16*	*$5,508.16*
	10 Month Employee Cost (Contract Aug-May)	**$2,626.82**	**$2,227.22**	**$2,001.62**	**$1,704.02**	**$967.22**	**$676.82**	**$550.82**
	12 Month Employee Cost (Contract July-June)	**$2,189.01**	**$1,856.01**	**$1,668.01**	**$1,420.01**	**$806.01**	**$564.01**	**$459.01**