OCTOBER 1, 2016-2017 CONFIDENTIAL/MANAGEMENT RATES

The District contributes **$14,100** towards the cost of the benefit package (based on Medical and Dental plan selected). If the rate for the benefit package is over this amount, the balance is paid by the employee in 11 or 12 month payroll deductions using pre-tax dollars:

October 1, 2016-September 30, 2017 EMPLOYEE DEDUCTIONS				
Dental Plan Selected	Kaiser HMO 2	Kaiser HMO 3	Blue Shield HMO 1	Blue Shield HMO 2
11 MONTH + DELTA INCENTIVE PPO	**No Cost**	**No Cost**	**$ 200.59**	**$ 138.40**
11 MONTH + DELTA PPO	**No Cost**	**No Cost**	**$ 187.27**	**$ 125.08**
11 MONTH + DELTACARE DHMO	**No Cost**	**No Cost**	**$ 180.55**	**$ 118.36**
12 MONTH + DELTA INCENTIVE PPO	**No Cost**	**No Cost**	**$ 183.87**	**$ 126.87**
12 MONTH + DELTA PPO	**No Cost**	**No Cost**	**$ 171.66**	**$ 114.66**
12 MONTH + DELTACARE DHMO	**No Cost**	**No Cost**	**$ 165.50**	**$ 108.50**

MEDICAL PLAN FEATURES				
Medical Plan Features	Kaiser HMO 2	Kaiser HMO 3	Blue Shield HMO 1	Blue Shield HMO 2
Calendar Year Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible (Annual)	None	None	None	None
Co-Insurance (Plan Pays)	100%	100%	100%	100%
Office Visit Copay - Primary Physician/Specialist	$15 / $15	$20 / $20	$10 / $30 Access+	$15 / $30 Access+
Out-of-Pocket Maximum - Individual / Family	$1,500 / $3,000	$1,500 / $3,000	$1,000 / $2,000	$1,500 / $3,000
Inpatient Hospitalization	100%	100%	100%	$250/Admin
Outpatient Diagnostic Tests	100%	100%	100%	100%
Emergency Services (Copay waived if admitted)	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Urgent Care Copay	$15	$20	$10 ($50 if Out of Service Area)	$15 ($50 if Out of Service Area)
Preventive Care	100%	100%	100%	100%
Mental Health/Substance Abuse - Outpatient Copay/Inpatient	$15 / 100%	$20 / 100%	$10 / 100%	$15 / $250, Admin
Chiropractic Copay/Visits per Yr.	$10 / 40 visits	$10 / 40 visits	$10 / 30 visits	$10 / 30 visits

PRESCRIPTION PLAN FEATURES				
Prescription Drugs Plan	Kaiser	Kaiser	Blue Shield	Blue Shield
Retail Pharmacy—30 Day Supply - Generic/Brand/Non-Formulary	$5/$10	$10/$20	$5/$10/$25	$10/$20/$35
Mail Order Pharmacy - Generic/Brand/Non-Formulary - Supply Limit	$15/$30 61-100 Days	$30/$60 61-100 Days	$10/$20/$50 90 Days	$20/$40/$70 90 Days

	Delta Incentive PPO Dental		Delta PPO Dental	
Dependents	11 Mo.	12 Mo	11 Mo	12 Mo
One Dependent	$ 77.59	$ 71.12	$ 61.26	$ 56.15
Two or More	$ 144.21	$ 132.19	$ 113.86	$ 104.37
There is no cost to add dependents on the DeltaCare DHMO plan				

Calculate your Payroll Deduction for your Core Benefits		
Rate for Benefit Package		
Cost to add dependent to dental plan	+	
Total paycheck deduction for Core benefits	=	

This summary is for comparison purposes only. Please review benefit booklet at www.cvtrust.org/plan-documents for actual benefits.

OCTOBER 1, 2016-2017 CONFIDENTIAL/MANAGEMENT RATES

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October 1, 2016-September 30, 2017 EMPLOYEE DEDUCTIONS					
Dental Plan Selected	Blue Shield PPO 3C	Blue Shield PPO 5C	Blue Shield PPO 7C	Blue Shield PPO 8C	Blue Shield HDHP PPO
11 MONTH + DELTA INCENTIVE PPO	**$ 534.40**	**$ 460.22**	**$ 341.31**	**$ 222.40**	**$ 322.77**
11 MONTH + DELTA PPO	**$ 521.08**	**$ 446.90**	**$ 327.99**	**$ 209.08**	**$ 309.45**
11 MONTH + DELTACARE DHMO	**$ 514.36**	**$ 440.18**	**$ 321.27**	**$ 202.36**	**$ 302.73**
12 MONTH + DELTA INCENTIVE PPO	**$ 489.87**	**$ 421.87**	**$ 312.87**	**$ 203.87**	**$ 295.87**
12 MONTH + DELTA PPO	**$ 477.66**	**$ 409.66**	**$ 300.66**	**$ 191.66**	**$ 283.66**
12 MONTH + DELTACARE DHMO	**$ 471.50**	**$ 403.50**	**$ 294.50**	**$ 185.50**	**$ 277.50**

MEDICAL PLAN FEATURES					
Dental Plan Selected	Blue Shield PPO 3C	Blue Shield PPO 5C	Blue Shield PPO 7C	Blue Shield PPO 8C	Blue Shield HDHP PPO
Calendar Year Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Deductible (Annual) - Individual / Family	$100 / $300	$100 / $300	$250 / $750	$500 / $1,500	$1,300 / $3,000
Co-Insurance (After Deductible)	100%	90%	80%	80%	80%
Office Visit Copay Primary Physician / Specialist	$20 / $20	$30 / $30	$30 / $30	$30 / $30	Ded, 80%
Out-of-Pocket Maximum* - Individual - Family	$1,250 $3,750	$1,250 $3,750	$2,000 $6,000	$3,250 $9,750	$4,250 $10,100
Inpatient Hospitalization	Ded, 100%	Ded, 90%	Ded, 80%	Ded, 80%	Ded, 80%
Outpatient Diagnostic Test	Ded, 100%	Ded, 90%	Ded, 80%	Ded, 80%	Ded, 80%
Emergency Services (Copay waived if admitted)	$100, Ded	$100, Ded, 90%	$100, Ded, 80%	$100, Ded, 80%	Ded, 80%
Urgent Care Copay	$20	$30	$30	$30	Ded, 80%
Preventive Care	100%	100%	100%	100%	100%
Mental Health/Substance Abuse - Outpatient Copay / Inpatient	$20 / 100%	$30 / Ded, 90%	$30/Ded, 80%	$30/Ded, 80%	Ded, 80%
Chiropractic (Copay may apply)	Ded, 100% 13 Visits/Year	Ded, 90% 13 Visits/Year	Ded, 80% 13 Visits/Year	Ded, 80% 13 Visits/Year	Ded, 80% 13 Visits/Year

*Out of Pocket maximum (includes deductible, coinsurance, medical & pharmacy cost)

ALL BLUE SHIELD PPO DRUG PRESCRIPTIONS ARE ADMINISTERED BY CVS CAREMARK*					
Prescription Plan Features	Blue Shield PPO 3C	Blue Shield PPO 5C	Blue Shield PPO 7C	Blue Shield PPO 8C	Blue Shield HDHP PPO
Retail —30 Days Supply Generic/Brand/Non-Formulary	$7/$25/$40	$7/$25/$40	$7/$25/$40	$7/$25/$40	Ded, 80%
Mail Order—90 Day Supply Generic/Brand/Non-Formulary	$15/$60/$90	$15/$60/$90	$15/$60/$90	$15/$60/$90	Ded, 80%

*For any brand drug with a generic equivalent available, the generic will be dispensed regardless of what a physician writes. The physician can specify "Dispense as Written" (DAW) or a plan participant can choose a brand drug, but they will always pay the generic plus the cost difference between the brand and generic when a brand name drug is selected and a generic is available.