

CVT Plan Matrix for  
LEA Bargaining Unit Members:

2005/2006

On March 21, 2005 the bargaining unit members of the Livermore Education Association voted to change our medical, vision and dental plans to a new administrator, the Central Valley Trust (CVT). Since then, our health care committee and district office have been working behind the scenes with the Central Valley Trust to get new health plans in place for the 2005-2006 school year. As many of you know, there will be some significant changes to our health care coverage including:

- 1) As negotiated, the district will be contributing \$10,000 per full-time equivalent bargaining unit member toward their health care plans. Any additional expenses beyond the district contribution will be deducted from your paycheck as usual on their ten- or twelve-month cycle.
- 2) The Central Valley Trust requires 100% full-time participation meaning that all bargaining unit members working 1FTE or more must choose a health care plan.
- 3) Health plans are based on a composite rate structure.
- 4) Part-time members have a choice as to participate in any or all medical, dental and vision plans. The district contribution will be pro-rated based on the percentage equivalent of their FTE status. (ie: .4FTE = 40% of contribution allocation = \$4,000)
- 5) There are seven plan design options to choose from and all bargaining unit members must complete new enrollment forms. We will be able to choose from four different Preferred Provider Organization (PPO) plans, two Kaiser Health Maintenance Organization (HMO) plans and one Pacificare HMO plan.
- 6) Blue Cross subscribers will not be served by Blue Cross for the first year of service. They will be served by Interplan PPO during that time.
- 7) For full-time employee couples in the LEA bargaining unit choosing PPO plans, CVT will charge 150% of the two premiums of the husband/wife or domestic partners combination, (based on the highest plan selected).

There will be a Health Care Faire Thursday & Friday; August 25-26, 2005 from 11:00AM – 5:00PM at the District Office Board Room to provide more information and assistance with enrollment forms. The open enrollment period will be August 10, 2005 through September 10, 2005 and our new plans will take effect October 1, 2005.

If you have any questions, please don't hesitate to contact me at 925-447-1199 or via e-mail at [president@livermoreteachers.org](mailto:president@livermoreteachers.org)





## 2005/2006 CVT PPO PLAN OPTIONS LIVERMORE EDUCATORS ASSOCIATION

BENEFIT	PLAN 4B	PLAN 6B	PLAN 7B	PLAN 8C
<b>MAJOR MEDICAL*</b>	<b>Deductible: \$100 Ind / \$300 family Coinsurance: 90/10 Out-of-Pocket Max: \$300 per person + deductible</b>	<b>Deductible: \$250 Ind / \$750 family Coinsurance 80/20 Out-of-Pocket Max: \$1,000 per person + deductible</b>	<b>Deductible: \$250 Ind / \$750 family Coinsurance: 80/20 Out-of-Pocket Max: \$1,000 per person + deductible</b>	<b>Deductible: \$500 Ind / \$1,500 family Coinsurance 80/20 Out-of-Pocket Max: \$2,000 per person + deductible</b>
<b>LIFETIME MAX PER PERSON</b>	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
<b>DOCTOR VISITS</b>	\$10 co-pay (co-pay not applied to deductible or out-of-pocket max)	\$10 co-pay (co-pay not applied to deductible or out-of-pocket max)	\$20 co-pay (co-pay not applied to deductible or out-of-pocket max)	Major Medical*
<b>ANNUAL PHYSICAL</b>	Up to \$200/year for employee and spouse; balance to Major Med*	Up to \$200/year for employee and spouse; balance to Major Med*	Up to \$200/year for employee and spouse; balance to Major Med*	Up to \$200/year for employee and spouse; balance to Major Med*
<b>IMMUNIZATIONS</b>	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.
<b>PREVENTIVE CARE FOR CHILDREN</b>	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible
<b>WELL WOMAN: PAP SMEAR/ MAMMOGRAM</b>	Major Medical*	Major Medical*	Major Medical*	Major Medical*
<b>OUTPATIENT X-RAY &amp; LAB</b>	Major Medical*	Major Medical*	Major Medical*	Major Medical*
<b>PHYSICAL THERAPY</b>	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* Non-Par Providers limited to 13 visits per year, max \$25 per visit.
<b>CHIROPRACTIC</b>	Major Medical* (Co-pay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Co-pay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Co-pay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* Non-Par Providers limited to 13 visits per year, max \$25 per visit.
<b>ACUPUNCTURE</b>	Major Medical* (Co-pay, if applicable) Max of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* Maximum of 12 visits per calendar year

<b>Page 2</b>	<b>PLAN 4B</b>		<b>PLAN 6B</b>		<b>PLAN 7B</b>		<b>PLAN 8C</b>	
<b>HOSPITAL INPATIENT</b>	Major Medical* Unlimited days, semi-private room		Major Medical* Unlimited days, semi-private room		Major Medical* Unlimited days, semi-private room		Major Medical* Unlimited days, semi-private room	
<b>HOSPITAL EMERGENCY ROOM</b>	\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)		\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)		\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)		\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	
<b>RADIATION THERAPY, CHEMOTHERAPY &amp; SURGERY</b>	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
<b>HOME HEALTH CARE</b>	Major Medical* Limited to 100 visits per calendar year		Major Medical* Limited to 100 visits per calendar year		Major Medical* Limited to 100 visits per calendar year		Major Medical* Limited to 100 visits per calendar year	
<b>HOSPICE</b>	100% of Covered Expense with a lifetime maximum of \$10,000		100% of Covered Expense with a lifetime maximum of \$10,000		100% of Covered Expense with a lifetime maximum of \$10,000		100% of Covered Expense with a lifetime maximum of \$10,000	
<b>DURABLE MEDICAL EQUIPMENT</b>	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
<b>AMBULANCE-GROUND/AIR</b>	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
<b>MENTAL HEALTH - INPATIENT</b>	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar yr.		After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar yr.		After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar yr.		After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar yr.	
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE PROFESSIONAL CHARGES (INPATIENT/OUTPATIENT)</b>	After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)		After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)		After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)		After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)	
<b>SUBSTANCE ABUSE INPATIENT</b>	\$300 Copay – After copay met, MHN Provider -- 100%. Non-MHN Provider – 50%. Two courses of treatment during lifetime.		\$300 Copay – After copay met, MHN Provider -- 100%. Non-MHN Provider – 50%. Two courses of treatment during lifetime.		\$300 Copay – After copay met, MHN Provider -- 100%. Non-MHN Provider – 50%. Two courses of treatment during lifetime.		\$300 Copay – After copay met, MHN Provider -- 100%. Non-MHN Provider – 50%. Two courses of treatment during lifetime.	
<b>PRESCRIPTION DRUGS (CO-PAYMENTS)</b>	<u>Retail</u> \$7 Generic \$15 Preferred \$30 Non-Pref. (30-day supply)	<u>Mail Order</u> \$15 Generic \$35 Preferred \$70 Non-Pref. (90-day supply)	<u>Retail</u> \$7 Generic \$15 Preferred \$30 Non-Pref. (30-day supply)	<u>Mail Order</u> \$15 Generic \$35 Preferred \$70 Non-Pref. (90-day supply)	<u>Retail</u> \$7 Generic \$15 Preferred \$30 Non-Pref. (30-day supply)	<u>Mail Order</u> \$15 Generic \$35 Preferred \$70 Non-Pref. (90-day supply)	<u>Retail</u> \$7 Generic \$25 Preferred \$40 Non-Pref. (30-day supply)	<u>Mail Order</u> \$15 Generic \$60 Preferred \$90 Non-Pref. (90-day supply)

ALL PERCENTAGES ARE BASED ON PAYMENTS TO PREFERRED HOSPITALS, PHYSICIANS AND OTHER NETWORK PROVIDERS. Major Medical\* - Deductible and coinsurance apply. Non-par (non-participating) providers receive payments based on the non-participating fee allowance and are subject to the deductibles and coinsurance of the plan. **THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.**

The following scenarios are for full-time (1FTE) bargaining unit members of the Livermore Education Association. If you are a part-time member who is choosing medical, dental and/or vision coverage, your contributions will vary depending on your full-time equivalent status and plan(s) chosen.

### **CVT Kaiser HMO Plan 3:**

\$10/office co-pay

\$35/Emergency Room co-pay

\$10 Generic/\$20 Brand Name Rx

Medical/Rx: \$771.00/month

Dental: \$99.38/month

Vision: \$20.29/month

Total Monthly \$890.67

Total Yearly \$10,688.04

Total out of pocket: \$688.04/year  
\$57.34/month

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### **CVT Kaiser HMO Plan 5:**

\$25/office co-pay

\$35/Emergency Room co-pay

\$10 Generic/\$20 Brand Name Rx

Medical/Rx: \$716.00/month

Dental: \$99.38/month

Vision: \$20.29/month

Total Monthly \$835.67

Total Yearly \$10,028.04

Total out of pocket: \$28.04/year  
\$2.34/month

The following scenarios are for full-time (1FTE) bargaining unit members of the Livermore Education Association. If you are a part-time member who is choosing medical, dental and/or vision coverage, your contributions will vary depending on your full-time equivalent status and plan(s) chosen.

**CVT Pacificare HMO Plan:**

\$0/office co-pay \*

\$35/Emergency Room co-pay (waived if admitted as an inpatient) \*

\$35/Urgently Needed Services (waived if admitted as an inpatient) \*

\$5 Retail Pharmacy Copayment (up to 30 days) / \$5 Mail Service Pharmacy Copayment (up to 90 days)

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\*When authorized through your Primary Care Physician in your Participating Medical Group.

Medical:	\$867.00/month
Rx plan B:	included in Medical
Dental:	\$99.38/month
Vision:	\$20.29/month

Total Monthly	\$986.67
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Total Yearly	\$11,840.04
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Total out of pocket:	\$1,840.04/year
	\$153.34/month

**2005/2006**  
**CVT HMO PLAN OPTIONS FOR KAISER AND PACIFICARE**  
**LIVERMORE EDUCATORS ASSOCIATION**

<b>BENEFIT</b>	<b>KAISER PLAN 3</b>	<b>KAISER PLAN 5</b>	<b>PACIFICARE</b>
<b>DOCTOR VISITS</b>	Covered, \$10 Copay	Covered, \$25 Copay	No Deductible Copay Out-of-Pocket Max: \$800 individual / \$2400 family
<b>ANNUAL PHYSICAL</b>	Covered, \$10 Copay	Covered, \$25 Copay	Covered, No Charge
<b>IMMUNIZATIONS</b>	Covered, No Charge	Covered, No Charge	Covered, No Charge
<b>PREVENTIVE CARE FOR CHILDREN</b>	Covered, No Charge Up To Age 2           After Age 2 - \$10 Copay	Covered, No Charge Up To Age 2           After Age 2 - \$25 Copay	Covered, No Charge
<b>WELL WOMAN: PAP SMEAR/ MAMMOGRAM</b>	Pap Smear-Covered, \$10 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$25 Copay Mammogram-Covered, No Charge	Covered, No Charge
<b>OUTPATIENT X-RAY &amp; LAB</b>	Covered, No Charge	Covered, No Charge	Covered, No Charge
<b>PHYSICAL THERAPY</b>	Covered, \$10 Copay	Covered, \$25 Copay	Covered, No Charge
<b>CHIROPRACTIC</b>	Not Covered	Not Covered	Not Covered
<b>ACUPUNCTURE</b>	Covered, \$10 Copay Referral by Plan Physician	Covered, \$25 Copay Referral by Plan Physician	Not Covered
<b>HOSPITAL INPATIENT</b>	Covered, No Charge	Covered, No Charge	Covered, No Charge
<b>HOSPITAL EMERGENCY ROOM</b>	Covered, \$35 Copay Waived if Admitted	Covered \$35 Copay Waived if Admitted	Covered, No Charge / ER \$35 Copay
<b>RADIATION THERAPY, CHEMOTHERAPY &amp; SURGERY</b>	Inpatient: Covered, No Charge Outpatient: \$10 Copay	Inpatient: Covered, No Charge Outpatient: \$25 Copay	Covered, No Charge
<b>HOME HEALTH CARE</b>	Covered, No Charge (Limits)	Covered, No Charge (limits)	Covered, No Charge
<b>HOSPICE</b>	Covered, No Charge	Covered, No Charge	Covered, No Charge (prognosis of life expectancy of one year or less)
<b>DURABLE MEDICAL EQUIPMENT</b>	Covered, No Charge In accord with DME Formulary	Covered, No Charge In accord with DME Formulary	Covered, No Charge

<i>Page 2</i>	<b>KAISER PLAN 3</b>		<b>KAISER PLAN 5</b>		<b>PACIFICARE</b>	
<b>AMBULANCE- GROUND/AIR</b>	Covered, No Charge, If Med. Necessary		Covered, No Charge, If Med. Necessary		No charge, if medically necessary	
<b>MENTAL HEALTH - INPATIENT</b>	Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		Covered, No Charge 45 days per calendar year (limits) No limits with AB88 Parity		30 days per calendar year; substance abuse limited to hospital detox plus residential treatment (limits)	
<b>MENTAL HEALTH OUTPATIENT</b>	Covered, \$10 Copay; 20 visits per calendar year No limits with AB88 Parity		Covered, \$25 Copay; 20 visits per calendar year No limits with AB88 Parity		30 visits per calendar year	
<b>SUBSTANCE ABUSE INPATIENT</b>	Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – No Charge Transitional Residential Recovery Services-\$100 per admission (limits) Residential Rehab (30 days cal yr) – No Charge (limits)		Detox – Covered, No Charge	
<b>SUBSTANCE ABUSE OUTPATIENT</b>	Covered, \$10 Copay for individual visits; \$5 Copay for group visits (no limits)		Covered, \$25 Copay for individual visits; \$5 Copay for group visits (no limits)		Detox – Covered, No Charge	
<b>OUT OF POCKET MAXIMUM</b>	\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$800 Per Person (3 Individual Maximums Per Family)	
<b>LIFETIME MAX PER PERSON</b>	No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum	
<b>PRESCRIPTION DRUGS (CO-PAYMENTS)</b>	<u>Retail</u> \$10 Generic \$20 Brand  (Up to 100 day supply)	<u>Mail Order</u> \$10 Generic \$20 Brand  Refills Only	<u>Retail</u> \$10 Generic \$20 Brand  (Up to 100 day supply)	<u>Mail Order</u> \$10 Generic \$20 Brand  Refills Only	<u>Retail: 30- Day Supply</u>  \$5 both Generic & Brand	<u>Mail Order: 90-Day Supply</u>  \$5 both Generic & Brand

**THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.**

## CVT's Delta Dental and VSP Vision Coverage

### **Dental:**

Composite Rate: \$99.38/month

Usual, Customary and Reasonable Fee Concept.

**Two Cleanings per year**  
**100% Diagnostics and Preventative**  
**Nitrous Oxide**

### **Basic, Crowns, & Cast Restorations:**

Co-Payment	70/30 First Year
	80/20 Second Year
	90/10 Third Year
	100% Fourth Year

(Co-Payment carries with us during transfer)

### **Prosthodontics:**

Co-Payment	70/30
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100% payment for dental services rendered in case of accident subject to separate \$1,000 maximum.

\$2,000 maximum per patient per calendar year.

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### **Vision:**

Composite Rate: \$20.29/month

**\$15.00 Office Co-Pay**  
**Eye Exam: Each 12 months**  
**Lenses: Each 12 months**  
**Frames: Each 12 months**