

CVT Plan Matrix for LEA Bargaining Unit Members as District-Paid Retirees:
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 LEA Health Care Committee and the LVJUSD 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.

Retiree health plans are tied to the health plans offered to active members and Option 1 retiree benefit levels are contractually consistent with the current benefits provided to all certificated employees.

Our existing plans will continue through September 30, 2005. You will not see any changes to your plans until October 1, 2005. To ensure that all active members and retirees are ready for their new plans, we are beginning preparations months ahead of time.

Some key significant changes to our health care coverage include:

- 1) As negotiated, the district will be contributing \$10,000 for each Full-Time Equivalent Option 1 retiree toward their health care plans or a proportional amount for each Part-Time Equivalent Option 1 retiree. Any additional expenses beyond the district contribution will be paid for by you. District-Paid retirees will be paying their contribution to the LVJUSD District Office while Self-Paid retirees will be paying their contribution to the LEA Retiree Trust Administrator, McMullan and Associates or directly to the Central Valley Trust.
- 2) Medical, vision, and dental plans for retirees are based on a tiered rate structure.
- 3) Retirees have a choice as to participate in any or all medical, dental, and vision plans.
- 4) There are seven plan design options to choose from for Option 1 retirees including four different Preferred Provider Organization (PPO) plans, two Kaiser Health Maintenance Organization (HMO) plans and one Pacificare HMO plan.
- 5) There are eight plan designs to choose from for Self-Paid Retirees including six different Preferred Provider Organization (PPO) plans, two Kaiser Senior Advantage Health Maintenance Organization (HMO) plans and one Pacificare Secure Horizons HMO plan..
- 6) All retirees currently using any district-based plans must complete new enrollment forms by September 10, 2005 in order to avoid their cancellation of coverage by the carrier.
- 7) Blue Cross subscribers will not be served by Blue Cross/Blue Shield for the first year of participation in CVT. They will have the option of Interplan PPO during the first year of service if they are located in California or Nevada or the CCN PPO Network if they are located outside of California and Nevada.

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

We will also be posting up-to-date information as it becomes available on the LEA website at www.livermoreteachers.org

The following scenarios are for retirees choosing medical, dental and vision. If you are a retiree who is only choosing medical, dental and/or vision coverage, your contributions will vary depending on your plan(s) chosen.

CVT PPO Plan 8C

\$500 Deductible

80% co-insurance

\$2,000 Out of Pocket Max. per person + deductible

Same for Office Visit Co-pay

Retail Rx (30 day) \$7/\$25/\$40 – Mail Order Rx (90 day) \$15/\$60/\$90

3 TIERED

Medical (E): \$424.00/month
 Rx (E): \$109.00/month

Medical (E+1): \$728.00/month
 Rx (E+1): \$187.00/month

Medical (E+Fam): \$921.00/month
 Rx (E+Fam): \$237.00/month

Dental (E): \$49.08/month
 Dental (E+1): \$88.87/month
 Dental (E+Fam): \$127.77/month

Vision (E): \$8.95/month
 Vision (E+1): \$16.83/month
 Vision (E+Fam): \$26.24/month

Total Monthly (E): \$591.03
 Total Monthly (E+1): \$1,020.70
 Total Monthly (E+Fam): \$1,312.01

Total Yearly (E): \$7,092.36
 Total Yearly (E+1): \$12,248.40
 Total Yearly (E+Fam): \$15,744.12

Total out of pocket (E): \$0/year
 \$0/month

Total out of pocket (E+1): \$2,248.40/year
 \$187.37/month

Total out of pocket (E+Fam): \$5,744.12/year
 \$478.68/month

CVT PPO Plan 7B

\$250 Deductible

80% co-insurance

\$1,000 Out of Pocket Max. per person + deductible

\$20 Office Visit Co-pay

Retail Rx (30 day) \$7/\$15/\$30 – Mail Order Rx (90 day) \$15/\$35/\$70

3 TIERED

Medical (E): \$482.00/month

Rx (E): \$121.00/month

Medical (E+1): \$828.00/month

Rx (E+1): \$208.00/month

Medical (E+Fam): \$1,047.00/month

Rx (E+Fam): \$262.00/month

Dental (E): \$49.08/month

Dental (E+1): \$88.87/month

Dental (E+Fam): \$127.77/month

Vision (E): \$8.95/month

Vision (E+1): \$16.83/month

Vision (E+Fam): \$26.24/month

Total Monthly (E): \$661.03

Total Monthly (E+1): \$1,141.70

Total Monthly (E+Fam): \$1,463.01

Total Yearly (E): \$7,932.36

Total Yearly (E+1): \$13,700.40

Total Yearly (E+Fam): \$17,556.12

Total out of pocket (E): \$0/year
\$0/month

Total out of pocket (E+1): \$3,700.40/year
\$308.37/month

Total out of pocket (E+Fam): \$7,556.12/year
\$629.68/month

CVT PPO Plan 6B

\$250 Deductible

80% co-insurance

\$1,000 Out of Pocket Max. per person + deductible

\$10 Office Visit Co-pay

Retail Rx (30 day) \$7/\$15/\$30 – Mail Order Rx (90 day) \$15/\$35/\$70

3 TIERED

Medical (E): \$487.00/month

Rx (E): \$121.00/month

Medical (E+1): \$837.00/month

Rx (E+1): \$208.00/month

Medical (E+Fam): \$1,057.00/month

Rx (E+Fam): \$262.00/month

Dental (E): \$49.08/month

Dental (E+1): \$88.87/month

Dental (E+Fam): \$127.77/month

Vision (E): \$8.95/month

Vision (E+1): \$16.83/month

Vision (E+Fam): \$26.24/month

Total Monthly (E): \$666.03

Total Monthly (E+1): \$1,150.70

Total Monthly (E+Fam): \$1,473.01

Total Yearly (E): \$7,992.36

Total Yearly (E+1): \$13,808.40

Total Yearly (E+Fam): \$17,676.12

Total out of pocket (E): \$0/year
\$0/month

Total out of pocket (E+1): \$3,808.40/year
\$317.37/month

Total out of pocket (E+Fam): \$7,676.12/year
\$639.68/month

CVT PPO Plan 4B

\$100 Deductible

90% co-insurance

\$300 Out of Pocket Max. per person + deductible

\$10 Office Visit Co-pay

Retail Rx (30 day) \$7/\$15/\$30 – Mail Order Rx (90 day) \$15/\$35/\$70

3 TIERED

Medical (E): \$535.00/month

Rx (E): \$121.00/month

Medical (E+1): \$919.00/month

Rx (E+1): \$208.00/month

Medical (E+Fam): \$1,163.00/month

Rx (E+Fam): \$262.00/month

Dental (E): \$49.08/month

Dental (E+1): \$88.87/month

Dental (E+Fam): \$127.77/month

Vision (E): \$8.95/month

Vision (E+1): \$16.83/month

Vision (E+Fam): \$26.24/month

Total Monthly (E): \$714.03

Total Monthly (E+1): \$1,232.70

Total Monthly (E+Fam): \$1,579.01

Total Yearly (E): \$8,568.36

Total Yearly (E+1): \$14,792.40

Total Yearly (E+Fam): \$18,948.12

Total out of pocket (E): \$0/year
\$0/month

Total out of pocket (E+1): \$4,792.40/year
\$399.37/month

Total out of pocket (E+Fam): \$8,948.12/year
\$745.68/month

**CENTRAL VALLEY TRUST
HEALTH PLANS
DISTRICT-PAID RETIREES
OCTOBER 1, 2005 - SEPTEMBER 30, 2006
REGION 2 - NEW - WITH 3% SURCHARGE**

PLAN NAME	UNDER AGE 65	MEDICARE A & B	MEDICARE B ONLY	*MEDICARE A ONLY	*WITHOUT MEDICARE
Plan 1					
RETIREE	\$580.00	\$283.00	\$484.00	\$473.00	\$925.00
RETIREE + ONE	\$999.00	\$598.00	\$1,000.00	\$981.00	\$1,881.00
RETIREE + FAMILY	\$1,263.00	\$860.00	\$1,264.00	\$1,246.00	\$2,148.00
Plan 2					
RETIREE	\$573.00	\$279.00	\$478.00	\$468.00	\$915.00
RETIREE + ONE	\$986.00	\$590.00	\$989.00	\$971.00	\$1,863.00
RETIREE + FAMILY	\$1,248.00	\$847.00	\$1,251.00	\$1,230.00	\$2,126.00
Plan 3					
RETIREE	\$555.00	\$268.00	\$461.00	\$451.00	\$886.00
RETIREE + ONE	\$953.00	\$567.00	\$953.00	\$935.00	\$1,802.00
RETIREE + FAMILY	\$1,207.00	\$815.00	\$1,206.00	\$1,185.00	\$2,058.00
Plan 4					
RETIREE	\$535.00	\$256.00	\$443.00	\$434.00	\$857.00
RETIREE + ONE	\$919.00	\$544.00	\$921.00	\$905.00	\$1,745.00
RETIREE + FAMILY	\$1,163.00	\$785.00	\$1,165.00	\$1,148.00	\$1,991.00
Plan 5					
RETIREE	\$529.00	\$253.00	\$439.00	\$429.00	\$848.00
RETIREE + ONE	\$910.00	\$539.00	\$913.00	\$895.00	\$1,727.00
RETIREE + FAMILY	\$1,150.00	\$777.00	\$1,154.00	\$1,132.00	\$1,970.00
Plan 6					
RETIREE	\$487.00	\$228.00	\$402.00	\$394.00	\$785.00
RETIREE + ONE	\$837.00	\$489.00	\$838.00	\$821.00	\$1,602.00
RETIREE + FAMILY	\$1,057.00	\$708.00	\$1,059.00	\$1,042.00	\$1,825.00
Plan 7					
RETIREE	\$482.00	\$225.00	\$398.00	\$389.00	\$777.00
RETIREE + ONE	\$828.00	\$484.00	\$830.00	\$811.00	\$1,586.00
RETIREE + FAMILY	\$1,047.00	\$700.00	\$1,048.00	\$1,027.00	\$1,806.00
Plan 8					
RETIREE	\$424.00	\$191.00	\$349.00	\$340.00	\$693.00
RETIREE + ONE	\$728.00	\$416.00	\$729.00	\$715.00	\$1,416.00
RETIREE + FAMILY	\$921.00	\$606.00	\$922.00	\$908.00	\$1,610.00
Plan 9					
RETIREE	\$370.00	\$160.00	\$301.00	\$295.00	\$612.00
RETIREE + ONE	\$635.00	\$349.00	\$631.00	\$620.00	\$1,251.00
RETIREE + FAMILY	\$804.00	\$508.00	\$798.00	\$785.00	\$1,423.00
Plan 10					
RETIREE	\$309.00	\$124.00	\$249.00	\$243.00	\$523.00
RETIREE + ONE	\$531.00	\$284.00	\$532.00	\$522.00	\$1,077.00
RETIREE + FAMILY	\$671.00	\$422.00	\$673.00	\$661.00	\$1,219.00
HDHP-1					
RETIREE	\$444.00	N/A	N/A	N/A	\$658.00
RETIREE + ONE	\$762.00	N/A	N/A	N/A	\$1,303.00
RETIREE + FAMILY	\$965.00	N/A	N/A	N/A	\$1,509.00
HDHP-2					
RETIREE	\$391.00	N/A	N/A	N/A	\$578.00
RETIREE + ONE	\$670.00	N/A	N/A	N/A	\$1,150.00
RETIREE + FAMILY	\$847.00	N/A	N/A	N/A	\$1,330.00

* Please refer to CVT Guidelines of Eligibility for Retirees regarding CVT requirements for Medicare Part A and B. These contributions are only quoted in special circumstances and should be verified with Member Services.

Note: Plans HDHP-1 and HDHP-2 include Rx benefits at the above rates.

How is my premium calculated if I am under 65 and my spouse is over 65?

If a retiree is under age 65 and has a spouse who is over age 65 and receiving Medicare, we will require a copy of the spouse's Medicare card. Medicare will be the primary insurance for the over age 65 spouse, the CVT plan will be secondary. Below is an example of the cost to a district paid retiree in this situation:

Plan 4B

Plan 4 Retiree under age 65	=\$535.00
+ Plan 4 Retiree over age 65 with Medicare A&B	=\$256.00
+ Rx Plan B for Retiree + One	=\$208.00
= Total amount.....	=\$999.00

2005/2006 CVT PPO PLAN OPTIONS LIVERMORE EDUCATORS ASSOCIATION

BENEFIT	PLAN 4B	PLAN 6B	PLAN 7B	PLAN 8C
MAJOR MEDICAL*	Deductible: \$100 Ind / \$300 family Coinsurance: 90/10 Out-of-Pocket Max: \$300 per person + deductible	Deductible: \$250 Ind / \$750 family Coinsurance 80/20 Out-of-Pocket Max: \$1,000 per person + deductible	Deductible: \$250 Ind / \$750 family Coinsurance: 80/20 Out-of-Pocket Max: \$1,000 per person + deductible	Deductible: \$500 Ind / \$1,500 family Coinsurance 80/20 Out-of-Pocket Max: \$2,000 per person + deductible
LIFETIME MAX PER PERSON	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
DOCTOR VISITS	\$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*
ANNUAL PHYSICAL	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*
IMMUNIZATIONS	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.
PREVENTIVE CARE FOR CHILDREN	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
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Major Medical*	Major Medical*	Major Medical*	Major Medical*
OUTPATIENT X-RAY & LAB	Major Medical*	Major Medical*	Major Medical*	Major Medical*
PHYSICAL THERAPY	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.
CHIROPRACTIC	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.
ACUPUNCTURE	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

Page 2	PLAN 4B		PLAN 6B		PLAN 7B		PLAN 8C	
HOSPITAL INPATIENT	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	
HOSPITAL EMERGENCY ROOM	\$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)	
RADIATION THERAPY, CHEMOTHERAPY & SURGERY	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
HOME HEALTH CARE	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	
HOSPICE	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	
DURABLE MEDICAL EQUIPMENT	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
AMBULANCE-GROUND/AIR	Major Medical*		Major Medical*		Major Medical*		Major Medical*	
MENTAL HEALTH - INPATIENT	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.	
MENTAL HEALTH & SUBSTANCE ABUSE PROFESSIONAL CHARGES (INPATIENT/OUTPATIENT)	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)	
SUBSTANCE ABUSE INPATIENT	\$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.	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<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.**

CVT Kaiser HMO Plan 3:

\$10/office co-pay

\$35/Emergency Room co-pay

\$10 Generic/\$20 Brand Name Rx

3 TIERED

Medical/Rx (E):	\$352.00/month
Medical/Rx (E+1):	\$704.00/month
Medical/Rx (E+Fam):	\$996.00/month

Dental (E):	\$49.08/month
Dental (E+1):	\$88.87/month
Dental (E+Fam):	\$127.77/month

Vision (E):	\$8.95/month
Vision (E+1):	\$16.83/month
Vision (E+Fam):	\$26.24/month

Total Monthly (E):	\$410.03
Total Monthly (E+1):	\$809.70
Total Monthly (E+Fam):	\$1,150.01

Total Yearly (E):	\$4,920.36
Total Yearly (E+1):	\$9,716.40
Total Yearly (E+Fam):	\$13,800.12

Total out of pocket (E):	\$0/year
	\$0/month

Total out of pocket (E+1):	\$0/year
	\$0/month

Total out of pocket (E+Fam):	\$3,800.12/year
	\$316.68/month

CVT Kaiser HMO Plan 5:

\$25/office co-pay

\$35/Emergency Room co-pay

\$10 Generic/\$20 Brand Name Rx

3 TIERED

Medical/Rx (E):	\$328.00/month
Medical/Rx (E+1):	\$655.00/month
Medical/Rx (E+Fam):	\$926.00/month

Dental (E):	\$49.08/month
Dental (E+1):	\$88.87/month
Dental (E+Fam):	\$127.77/month

Vision (E):	\$8.95/month
Vision (E+1):	\$16.83/month
Vision (E+Fam):	\$26.24/month

Total Monthly (E):	\$386.03
Total Monthly (E+1):	\$760.70
Total Monthly (E+Fam):	\$1,080.01

Total Yearly (E):	\$4,632.36
Total Yearly (E+1):	\$9,128.40
Total Yearly (E+Fam):	\$12,960.12

Total out of pocket (E):	\$0/year
	\$0/month

Total out of pocket (E+1):	\$0/year
	\$0/month

Total out of pocket (E+Fam):	\$2,960.12/year
	\$246.68/month

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)

*

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

3 TIERED

Medical/Rx (E):	\$483.00/month
Medical/Rx (E+1):	\$832.00/month
Medical/Rx (E+Fam):	\$1,097.00/month

Dental (E):	\$49.08/month
Dental (E+1):	\$88.87/month
Dental (E+Fam):	\$127.77/month

Vision (E):	\$8.95/month
Vision (E+1):	\$16.83/month
Vision (E+Fam):	\$26.24/month

Total Monthly (E):	\$541.03
Total Monthly (E+1):	\$937.70
Total Monthly (E+Fam):	\$1,251.01

Total Yearly (E):	\$6,492.36
Total Yearly (E+1):	\$11,252.40
Total Yearly (E+Fam):	\$15,012.12

Total out of pocket (E):	\$0/year \$0/month
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Total out of pocket (E+1):	\$1,252.40/year \$104.37/month
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Total out of pocket (E+Fam):	\$5,012.12/year \$417.68/month
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2005/2006
CVT HMO PLAN OPTIONS FOR KAISER AND PACIFICARE
LIVERMORE EDUCATORS ASSOCIATION

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

<i>Page 2</i>	KAISER PLAN 3		KAISER PLAN 5		PACIFICARE	
AMBULANCE- GROUND/AIR	Covered, No Charge, If Med. Necessary		Covered, No Charge, If Med. Necessary		No charge, if medically necessary	
MENTAL HEALTH - INPATIENT	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)	
MENTAL HEALTH OUTPATIENT	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	
SUBSTANCE ABUSE INPATIENT	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	
SUBSTANCE ABUSE OUTPATIENT	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	
OUT OF POCKET MAXIMUM	\$1,500 Per Person \$3,000 Per Family		\$1,500 Per Person \$3,000 Per Family		\$800 Per Person (3 Individual Maximums Per Family)	
LIFETIME MAX PER PERSON	No Lifetime Maximum		No Lifetime Maximum		No Lifetime Maximum	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<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:

Dental (E):	\$49.08/month
Dental (E+1):	\$88.87/month
Dental (E+Fam):	\$127.77/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.

Vision:

Vision (E):	\$8.95/month
Vision (E+1):	\$16.83/month
Vision (E+Fam):	\$26.24/month

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