

2023-2024 Certificated Health Insurance Rates  
FOR ALL TAL UNIT MEMBERS - **SPOUSE RATES**

**Open Enrollment Period is August 1st, - August 25th, 2023. Return to Risk Management by August 25th, 2023.**

Please make your selection by **initialing through** the box of your **plan choice**. Your selection for the 2023-2024 plan year will be effective October 1, 2023.

**You must complete a form whether or not you are making a change. For plan changes, you must also go to [mycvtrust.org](http://mycvtrust.org) to indicate your new plan selection.**

BCI/BCR 12	
BLUE CROSS 100% Plan 1A #13929A	
Deductible	\$0
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$10
ER \$100	Non-Emergency ER \$175
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Brand) \$5/\$22	
90 Day RX mail order \$10/\$44	
\$ 1,961 x 12 Months =	\$ 23,532.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 25,124.16
Benefit Cap	\$ 15,258.00
Difference	\$ 9,866.16
<b>Monthly Payment</b>	<b>\$ 822.18</b>

BCI/BCR 02	
BLUE CROSS 100% Plan 3A #13929C	
Deductible	\$100 ind/\$200 family
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$20
ER \$100	Non-Emergency ER \$175
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Brand) \$5/\$22	
90 Day RX mail order \$10/\$44	
\$ 1,811 x 12 Months =	\$ 21,732.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 23,324.16
Benefit Cap	\$ 15,258.00
Difference	\$ 8,066.16
<b>Monthly Payment</b>	<b>\$ 672.18</b>

BCT/BRT 02	
BLUE CROSS 90% Plan 4B #13929D	
Deductible	\$100 ind/\$200 family
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$20
ER \$100	Non-Emergency ER \$175
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Preferred/Non-Preferred) \$7/\$15/\$30	
90 day RX mail order \$15/\$35/\$70	
\$ 1,731 x 12 Months =	\$ 20,772.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 22,364.16
Benefit Cap	\$ 15,258.00
Difference	\$ 7,106.16
<b>Monthly Payment</b>	<b>\$ 592.18</b>

BCI/BCR 42	
BLUE CROSS 90% Plan WELLNESS #1841NA	
Deductible	\$500 ind/\$1000 family
OOP Max	\$1750 ind / \$3500 family
Office Visit Co-Pay	\$20 primary/\$40 specialist
ER \$100	Non-Emergency ER \$175
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Preferred/Non-Preferred) \$7/\$25/\$40	
90 Day RX mail order \$15/\$60/\$90	
\$ 1,615 x 12 Months =	\$ 19,380.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 20,972.16
Benefit Cap	\$ 15,258.00
Difference	\$ 5,714.16
<b>Monthly Payment</b>	<b>\$ 476.18</b>

BCT/BRT 12	
BLUE CROSS 80% Plan 7C #13929G	
Deductible	\$250 ind/\$500 family
OOP Max	\$2000 ind / \$4000 family
Office Visit Co-Pay	\$30
ER \$100	Non-Emergency ER \$175
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Preferred/Non-Preferred) \$7/\$25/\$40	
90 day RX mail order \$15/\$60/\$90	
\$ 1,561 x 12 Months =	\$ 18,732.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 20,324.16
Benefit Cap	\$ 15,258.00
Difference	\$ 5,066.16
<b>Monthly Payment</b>	<b>\$ 422.18</b>

BCT/BRT 22	
BLUE CROSS 90% PPO HDHP 1 #13931N	
Deductible	\$1500 ind/\$3000 family <small>no ind limit applies to family</small>
OOP Max	\$4250 ind/\$8500 family
Office Visit Co-Pay	Major Medical *
Emergency Room	Major Medical *
Prescription Drugs - Major Medical *	
* paid at 90% after deductible is met	
\$ 1,085 x 12 Months =	\$ 13,020.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 14,612.16
Benefit Cap	\$ 15,258.00
Difference	\$ (645.84)
<b>Monthly Payment</b>	<b>\$ -</b>

BCT/BRT 42	
CVT 70% Bronze Plan PPO #1853YA	
Deductible	\$5000 ind/\$10000 family
OOP Max	\$6350 ind / \$12700 family
Office Visit Co-Pay	See SBC
Emergency/Urgent Care	See SBC
30 Day RX Sub. to deductible then \$25/\$50 (Generic/Brand)	
90 Day RX Sub. to deductible then \$50/\$100 (Generic/Brand)	
\$ 898 x 12 Months =	\$ 10,776.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 12,368.16
Benefit Cap	\$ 15,258.00
Difference	\$ (2,889.84)
<b>Monthly Payment</b>	<b>\$ -</b>

BCT/BRT 31	
Blue Shield HMO 2 100% Plan #H55709	
Deductible	\$0
OOP Max	\$1500 ind / \$3000 family
Office Visit Co-Pay	\$15 primary/\$30 specialist
Emergency/Ambulance	\$100
30 Day RX (Generic/Formulary/Non-Formulary) \$7/\$15/\$30	
90 day RX mail order \$15/\$35/\$70	
\$ 2,147 x 12 Months =	\$ 25,764.00
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 27,356.16
Benefit Cap	\$ 15,258.00
Difference	\$ 12,098.16
<b>Monthly Payment</b>	<b>\$ 1,008.18</b>

**DENTAL AND VISION PREMIUMS INCLUDED  
IN ALL MEDICAL PLANS**

**Delta Dental PPO Premier Incentive #7901-2011**  
\$1900 max, 2 cleanings per year, Ortho 50/50 \$500 lifetime

**Vision Service Plan C #2025584A**  
\$5/\$20 co-pay, \$150 frame/ \$120 contact allotment

◦ Dependents are eligible for insurance until age 26

◦ The first deduction will come out of the September check. If a deduction does not come out of a check, it is your responsibility to contact Risk Management to make payment arrangements.

2023-2024 Certificated Health Insurance Rates - FOR ALL TAL UNIT MEMBERS - **SPOUSE RATES**

**Initial through the box of your plan choice. Return by August 25th , 2023.**

**KS1/KR1 01**

<b>Kaiser 1 w/ Chiro #0406-0000C</b>	
Office Visit Co-Pay	\$10
OOP Max	\$1500 ind / \$3000 family
Emergency Room	\$100
Chiropractic	\$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) \$5/\$10 100 day RX mail order \$10/\$20	
\$ 1,394.39 x 12 Months =	\$ 16,732.68
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 18,324.84
Benefit Cap	\$ 15,258.00
Difference	\$ 3,066.84
<b>Monthly Payment</b>	<b>\$ 255.57</b>

**KS1/KR1 02**

<b>Kaiser 2 w/ Chiro #0406-0037C</b>	
Office Visit Co-Pay	\$15
OOP Max	\$1500 ind / \$3000 family
Emergency Room	\$100
Chiropractic	\$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) \$5/\$10 100 day RX mail order \$10/\$20	
\$ 1,354.39 x 12 Months =	\$ 16,252.68
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 17,844.84
Benefit Cap	\$ 15,258.00
Difference	\$ 2,586.84
<b>Monthly Payment</b>	<b>\$ 215.57</b>

**KS1/KR1 03**

<b>Kaiser 3 w/ Chiro #0406-0040C</b>	
Office Visit Co-Pay	\$20
OOP Max	\$1500 ind / \$3000 family
Emergency Room	\$100
Chiropractic	\$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) \$10/\$20 100 day RX mail order \$20/\$40	
\$ 1,291.39 x 12 Months =	\$ 15,496.68
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 17,088.84
Benefit Cap	\$ 15,258.00
Difference	\$ 1,830.84
<b>Monthly Payment</b>	<b>\$ 152.57</b>

**KS1/KR1 09**

<b>Kaiser Wellness w/ Chiro #0406-0375C</b>	
Office Visit Co-Pay	\$20 primary/\$40 specialist
OOP Max	\$1500 ind / \$3000 family
Emergency Room	\$100
Ambulance	\$100
Outpatient/Inpatient Hospitalization	\$500
Chiropractic	\$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) \$10/\$25 100 day RX mail order \$20/\$50	
\$ 1,275.39 x 12 Months =	\$ 15,304.68
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 16,896.84
Benefit Cap	\$ 15,258.00
Difference	\$ 1,638.84
<b>Monthly Payment</b>	<b>\$ 136.57</b>

**KS1/KR1 07**

<b>Kaiser 7 WITH Chiro #0406-0052C</b>	
Office Visit Co-Pay	\$35
OOP Max	\$1500 ind / \$3000 family
Emergency Room / Ambulance	\$100
Outpatient/Inpatient Hospitalization	\$250
Durable Medical Equipment - Paid at 80%	
Chiropractic	\$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) \$10/\$30 100 day RX mail order \$20/\$60	
\$ 1,230.39 x 12 Months =	\$ 14,764.68
Vision Service Plan C	\$ 322.08
Delta Dental Premier Incentive PPO	\$ 1,270.08
Total Annual Premium	\$ 16,356.84
Benefit Cap	\$ 15,258.00
Difference	\$ 1,098.84
<b>Monthly Payment</b>	<b>\$ 91.57</b>

Plan summaries available in Risk Management or [www.lancsd.org](http://www.lancsd.org)

<b>FOR OFFICE USE ONLY</b>	
DD1/DR1 01	\$105.84/month
VSP/VIR 01	\$26.84/month
Medical/Dental/Vision Cap	\$15,258.00
M Only Cap (15,258-1270.08-322.08)	= \$13,665.84
District	= \$1,138.82/month

I understand that it is my responsibility to update MyCVT, **within 30 days**, for any life event, i.e.:

- Marriage/Divorce (marriage certificate/divorce decree required)
- Birth/Adoption (birth certificate/adoption papers required)
- Loss/Acquisition of coverage (documentation required)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
School Site

\_\_\_\_\_  
Date

Check here if your spouse is employed with the LANCASTER SCHOOL DISTRICT or with ANOTHER SCHOOL DISTRICT & ENROLLED IN CVT INSURANCE (ON A COMPOSITE RATE), and complete spouse information below.

\_\_\_\_\_  
Spouse's Name

\_\_\_\_\_  
Spouse's School District