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

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 mycvt.cvtrust.org to indicate your new plan selection.

BCI/BCR 11

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	
$ 2,614 x 12 Months =	$ 31,368.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 32,960.16
Benefit Cap	$ 15,258.00
Difference	$ 17,702.16
Monthly Payment	$ 1,475.18

BCI/BCR 01

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	
$ 2,414 x 12 Months =	$ 28,968.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 30,560.16
Benefit Cap	$ 15,258.00
Difference	$ 15,302.16
Monthly Payment	$ 1,275.18

BCT/BRT 01

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	
$ 2,308 x 12 Months =	$ 27,696.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 29,288.16
Benefit Cap	$ 15,258.00
Difference	$ 14,030.16
Monthly Payment	$ 1,169.18

BCI/BCR 41

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	
$ 2,153 x 12 Months =	$ 25,836.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 27,428.16
Benefit Cap	$ 15,258.00
Difference	$ 12,170.16
Monthly Payment	$ 1,014.18

BCT/BRT 11

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	
$ 2,081 x 12 Months =	$ 24,972.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 26,564.16
Benefit Cap	$ 15,258.00
Difference	$ 11,306.16
Monthly Payment	$ 942.18

BCT/BRT 21

BLUE CROSS 90% PPO HDHP 1 #13931N	
Deductible	$1500 ind/$3000 family no ind limit applies to family
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	
$ 1,446 x 12 Months =	$ 17,352.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 18,944.16
Benefit Cap	$ 15,258.00
Difference	$ 3,686.16
Monthly Payment	$ 307.18

BCT/BRT 41

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)	
$ 1,197 x 12 Months =	$ 14,364.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 15,956.16
Benefit Cap	$ 15,258.00
Difference	$ 698.16
Monthly Payment	$ 58.18

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
Monthly Payment	$ 1,008.18

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

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

KS1/KR1 01

Kaiser 1 w/ Chiro #0406-0000C	
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
Monthly Payment	$ 255.57

KS1/KR1 02

Kaiser 2 w/ Chiro #0406-0037C	
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
Monthly Payment	$ 215.57

KS1/KR1 03

Kaiser 3 w/ Chiro #0406-0040C	
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
Monthly Payment	$ 152.57

KS1/KR1 09

Kaiser Wellness w/ Chiro #0406-0375C	
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
Monthly Payment	$ 136.57

KS1/KR1 07

Kaiser 7 WITH Chiro #0406-0052C	
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
Monthly Payment	$ 91.57

Plan summaries available in Risk Management or www.lancsd.org

FOR OFFICE USE ONLY
DD1/DR1 01 $105.84/month
VSP/VIR 01 $26.84/month
Medical/Dental/Vision Cap $15,258.00
M Only Cap (15,258-1,270.08-322.08) = $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