2024-2025 Certificated Health Insurance Rates
FOR ALL TAL UNIT MEMBERS - ***SPOUSE RATES***

Open Enrollment Period is July 24th, - August 23rd, 2024. Return to Risk Management by August 23rd, 2024.

Please make your selection by initialing through the box of your plan choice. Your selection for the 2024-2025 plan year will be effective October 1, 2024.

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 12

BLUE CROSS 100% Plan 1A #13929A	
Deductible	$0
OOP Max	$1250 ind / $2500 family
Office Visit Co-Pay	$10
ER $150	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Brand) $5/$22 90 Day RX mail order $10/$44	
$ 2,059 x 12 Months =	$ 24,708.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 26,300.16
Benefit Cap	$ 16,058.00
Difference	$ 10,242.16
Monthly Payment	$ 853.51

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 $150	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Brand) $5/$22 90 Day RX mail order $10/$44	
$ 1,902 x 12 Months =	$ 22,824.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 24,416.16
Benefit Cap	$ 16,058.00
Difference	$ 8,358.16
Monthly Payment	$ 696.51

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 $150	
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	
$ 1,818 x 12 Months =	$ 21,816.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 23,408.16
Benefit Cap	$ 16,058.00
Difference	$ 7,350.16
Monthly Payment	$ 612.51

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 $150	
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	
$ 1,695 x 12 Months =	$ 20,340.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 21,932.16
Benefit Cap	$ 16,058.00
Difference	$ 5,874.16
Monthly Payment	$ 489.51

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 $150	
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	
$ 1,639 x 12 Months =	$ 19,668.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 21,260.16
Benefit Cap	$ 16,058.00
Difference	$ 5,202.16
Monthly Payment	$ 433.51

BCT/BRT 22

BLUE CROSS 90% PPO HDHP 1 #13931N	
Deductible	$1600 ind/$3200 family no ind limit applies to family
OOP Max	$5000 ind/$10000 family
Office Visit Co-Pay	Major Medical *
Emergency Room	Major Medical *
Prescription Drugs - Major Medical * * paid at 90% after deductible is met	
$ 1,138 x 12 Months =	$ 13,656.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 15,248.16
Benefit Cap	$ 16,058.00
Difference	$ (809.84)
Monthly Payment	$ -

BCT/BRT 42

CVT 70% Bronze Plan PPO #1853YA	
Deductible	$5000 ind/$10000 family
OOP Max	$7000 ind / $14000 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)	
$ 927 x 12 Months =	$ 11,124.00
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 12,716.16
Benefit Cap	$ 16,058.00
Difference	$ (3,341.84)
Monthly Payment	$ -

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	
$ 2,308 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	$ 16,058.00
Difference	$ 13,230.16
Monthly Payment	$ 1,102.51

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, $200 frame/ $150 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.

2024-2025 Certificated Health Insurance Rates - FOR ALL TAL UNIT MEMBERS - **SPOUSE RATES**

Initial through the box of your plan choice. Return by August 23rd , 2024.

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	
$ 1,567.39 x 12 Months =	$ 18,808.68
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 20,400.84
Benefit Cap	$ 16,058.00
Difference	$ 4,342.84
Monthly Payment	$ 361.90

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	
$ 1,522.39 x 12 Months =	$ 18,268.68
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 19,860.84
Benefit Cap	$ 16,058.00
Difference	$ 3,802.84
Monthly Payment	$ 316.90

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	
$ 1,451.39 x 12 Months =	$ 17,416.68
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 19,008.84
Benefit Cap	$ 16,058.00
Difference	$ 2,950.84
Monthly Payment	$ 245.90

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	
$ 1,432.39 x 12 Months =	$ 17,188.68
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 18,780.84
Benefit Cap	$ 16,058.00
Difference	$ 2,722.84
Monthly Payment	$ 226.90

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	
$ 1,381.39 x 12 Months =	$ 16,576.68
Vision Service Plan C	$ 322.08
Delta Dental Premier Incentive PPO	$ 1,270.08
Total Annual Premium	$ 18,168.84
Benefit Cap	$ 16,058.00
Difference	$ 2,110.84
Monthly Payment	$ 175.90

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 $16,058
M Only Cap (16,050-1270.08-322.08) = $14,465.84
District = $1,205.49/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