LANCASTER SCHOOL DISTRICT

2024-2025 HEALTH BENEFITS FOR MANAGEMENT/CONFIDENTIAL/NURSES/PSYCHOLOGISTS/BOARD (SISC)

The plan options have remained the same as last year. Please make your selection by initialing in the box of your choice. Return to Risk Management by June 28, 2024. Your plan for the 2024-2025 school year will be effective October 1, 2024.

BLUE CROSS 100% Plan A		-
	•	00/\$300
OOP Max (Individual/Family) \$1,000/\$3,0		
Rx OOP Max (Individual/Family) \$2,500/\$		00
Office Visit Co-Pay \$20 (first 3 visits free)	
Emergency Room/Ambulance \$100		
30 Day Pharmacy (Generic/Brand)		
30 Day Costco (Generic/Brand)		/\$35
90 Day Costco (Generic/Brand)	\$0	/\$90
\$ 1,802 x 12 Months =	\$	21,624.00
Vision Service Plan C	\$	338.40
Delta Dental PPO Incentive	\$	1,165.20
Total Annual Premium	\$	23,127.60
Benefit Cap	\$	
Difference	\$	
Monthly Payment	Ś	589.13
	т	000120
BC3/BR3 06 ↑ KS3/KR3		
BC3/BR3 06 ↑ KS3/KR3		
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN	03、	
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0	03、	
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0	03 、 00	
BC3/BR3 06 ↑KS3/KR3Kaiser Plan 3Group #234480-0015AMNDeductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$10	03 、 00	
BC3/BR3 06 ↑KS3/KR3Kaiser Plan 3Group #234480-0015AMNDeductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$10Emergency Room \$100/ Ambulance \$10	03 × 00	↓ \$10
BC3/BR3 06 ↑KS3/KR3Kaiser Plan 3Group #234480-0015AMNDeductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$10Emergency Room\$100 / Ambulance100 Day Pharmacy (Generic/Brand)	03 × 00	↓ \$10
BC3/BR3 06 ↑KS3/KR3Kaiser Plan 3Group #234480-0015AMNDeductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$10Emergency Room\$100Emergency Room\$100Ambulance\$100Hearing Aid\$500 / 1 per ear / 2 per	03 、 00 50 36 I	↓ \$10
BC3/BR3 06 ↑KS3/KR3Kaiser Plan 3Group #234480-0015AMNDeductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$10Emergency Room\$100 / Ambulance100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 perChiro\$10 co-pay/30 visits	00 00 50 10 10 10 10 10 10 10 10 10 10 10 10 10	↓ \$10 months
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$10 Emergency Room \$100 / Ambulance \$10 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,486 x 12 Months =	00 00 50 \$ \$ \$ \$	↓ \$10 months 17,832.00
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$10 Emergency Room \$100 / Ambulance \$1 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,486 x 12 Months = Vision Service Plan C	000 50 50 \$ \$ \$ \$ \$ \$	↓ \$10 months 17,832.00 338.40
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$10 Emergency Room \$100 / Ambulance \$10 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,486 x 12 Months = Vision Service Plan C Delta Dental PPO Incentive	00 50 50 \$ \$ \$ \$ \$ \$ \$ \$	↓ \$10 months 17,832.00 338.40 1,165.20
BC3/BR3 06 ↑ KS3/KR3 Kaiser Plan 3 Group #234480-0015AMN Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$10 Emergency Room \$100 / Ambulance \$1 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,486 x 12 Months = Vision Service Plan C Delta Dental PPO Incentive Total Annual Premium	000 50 50 \$ \$ \$ \$ \$ \$	↓ \$10 months 17,832.00 338.40 1,165.20 19,335.60

BLUE CROSS 90% Plan C Group #	40651D
Deductible (Individul/Family) \$200/\$500	
OOP Max (Individual/Family) \$1,000/\$3,0	000
Rx OOP Max (Individual/Family) \$2,500/5	\$3,500
Office Visit Co-Pay \$20 (first 3 visits free	e)
Emergency Room/Ambulance \$100	
30 Day Pharmacy (Generic/Brand)	\$9/\$35
30 Day Costco (Generic/Brand)	\$0/\$35
90 Day Costco (Generic/Brand)	\$0/\$90
\$ 1,696 x 12 Months =	\$ 20,352.00
Vision Service Plan C	\$ 338.40
Delta Dental PPO Incentive	\$ 1,165.20
Total Annual Premium	\$ 21,855.60
Benefit Cap	\$ 16,058.00
Difference	\$ 5,797.60
Monthly Payment	\$ 483.13
	KR3 10 ↓
Kaiser Plan 2 Group #234480-00	
Kaiser Plan 2Group #234480-00Deductible\$0	16AMN
Kaiser Plan 2 Group #234480-00 Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,	16AMN
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20	16AMN 000
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$	16AMN 000 \$50
Kaiser Plan 2Group #234480-00Deductible\$0DOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)	16AMN 000 \$50 \$10/\$20
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 per	16AMN 000 \$50 \$10/\$20
Kaiser Plan 2Group #234480-00Deductible\$0DOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits	16AMN 000 \$50 \$10/\$20 36 months
Kaiser Plan 2Group #234480-00Deductible\$0DOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x12 Months =	16AMN 000 \$50 \$10/\$20 36 months \$ 17,448.00
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x 12 Months =Vision Service Plan C	16AMN 000 \$50 \$10/\$20 36 months \$ 17,448.00 \$ 338.40
Kaiser Plan 2Group #234480-00Deductible\$0DOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x 12 Months =Vision Service Plan CDelta Dental PPO Incentive	16AMN 000 \$50 \$10/\$20 36 months \$ 17,448.00 \$ 338.40 \$ 1,165.20
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x 12 Months =Vision Service Plan CDelta Dental PPO IncentiveTotal Annual Premium	16AMN 000 \$50 \$10/\$20 36 months \$ 17,448.00 \$ 338.40 \$ 1,165.20 \$ 18,951.60
Kaiser Plan 2Group #234480-00Deductible\$0DOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x\$1,454 xVision Service Plan CDelta Dental PPO IncentiveTotal Annual PremiumBenefit Cap	16AMN 0000 \$50 \$10/\$20 36 months \$ 17,448.00 \$ 338.40 \$ 1,165.20 \$ 18,951.60 \$ 16,058.00
Kaiser Plan 2Group #234480-00Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$20Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits\$1,454 x 12 Months =Vision Service Plan CDelta Dental PPO IncentiveTotal Annual Premium	16AMN 000 \$50 \$10/\$20 36 months \$ 17,448.00 \$ 338.40 \$ 1,165.20 \$ 18,951.60

BLUE CROSS 80% Plan E Group # 40651	LE	
Deductible (Individul/Family) \$300/\$600		
OOP Max (Individual/Family) \$1,000/\$3,0		
Rx OOP Max (Individual/Family) \$2,500/\$		00
Office Visit Co-Pay \$20 (first 3 visits free	2)	
Emergency Room/Ambulance \$100		
30 Day Pharmacy (Generic/Brand)		
	\$0/\$35	
90 Day Costco (Generic/Brand)	\$C	/\$90
\$ 1,585 x 12 Months =	\$	
Vision Service Plan C		338.40
Delta Dental PPO Incentive		1,165.20
Total Annual Premium		20,523.60
Benefit Cap		16,058.00
Difference		4,465.60
Monthly Payment		372.13
BC3/BR3 05 个 KS	3/K	R3 04 ↓
BC3/BR3 05 个 KS Kaiser Plan 4 Group #234480-00	3/K	R3 04 ↓
BC3/BR3 05 个 KS Kaiser Plan 4 Group #234480-00 Deductible \$0	З/К 17/	R3 04 ↓ \MN
BC3/BR3 05 个 KS Kaiser Plan 4 Group #234480-00	З/К 17/	R3 04 ↓ \MN
BC3/BR3 05 ↑KSKaiser Plan 4Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30	з/к 17/ 000	R3 04 ↓ \MN
BC3/BR3 05 ↑KSKaiser Plan 4Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$	з/к 174 000	R3 04 ↓ \MN
BC3/BR3 05 ↑KS:Kaiser Plan 4Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)	з/к 17/ 000 550 \$	R3 04 ↓ MMN 10/\$30
BC3/BR3 05 ↑KSKaiser Plan 4Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 per	з/к 17/ 000 550 \$	R3 04 ↓ MMN 10/\$30
BC3/BR3 05 ↑KSKaiser Plan 4 Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 perChiro \$10 co-pay/30 visits	3/K 17 0000 \$50 \$ 36	R3 04 ↓ MMN 10/\$30 months
BC3/BR3 05 ↑KSKaiser Plan 4 Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing Aid\$500 / 1 per ear / 2 perChiro\$10 co-pay/30 visits\$1,428 x 12 Months =	3/K 17 0000 \$500 \$ 366 \$	R3 04 ↓ MMN 10/\$30 months 17,136.00
BC3/BR3 05 ↑ KS3 Kaiser Plan 4 Group #234480-00 Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$30 Emergency Room \$100 / Ambulance \$ 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,428 x 12 Months = Vision Service Plan C	3/K 17/ 0000 \$500 \$360 \$ \$ \$	R3 04 ↓ MMN 10/\$30 months 17,136.00 338.40
BC3/BR3 05 ↑ KS Kaiser Plan 4 Group #234480-00 Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$30 Emergency Room \$100 / Ambulance \$ 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,428 x 12 Months = Vision Service Plan C Delta Dental PPO Incentive	3/K 17/ 0000 \$500 \$ 360 \$ \$ \$ \$ \$	R3 04 ↓ MN 10/\$30 months 17,136.00 338.40 1,165.20
BC3/BR3 05 ↑ KS3 Kaiser Plan 4 Group #234480-00 Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$30 Emergency Room \$100 / Ambulance \$ 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,428 x 12 Months = Vision Service Plan C Delta Dental PPO Incentive Total Annual Premium	3/K 17/ 0000 \$ 500 \$ 360 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	R3 04 ↓ MMN 10/\$30 months 17,136.00 338.40 1,165.20 18,639.60
BC3/BR3 05 ↑KSKaiser Plan 4 Group #234480-00Deductible\$0Deductible\$0OOP Max (Individual/Family)\$1,500/\$3,0Office Visit Co-Pay\$30Emergency Room\$100 / Ambulance \$100 Day Pharmacy (Generic/Brand)Hearing AidHearing Aid\$500 / 1 per ear / 2 perChiro\$10 co-pay/30 visits\$1,428 x12 Months =Vision Service Plan CDelta Dental PPO IncentiveTotal Annual PremiumBenefit Cap	3/K 17 500 550 \$ 36 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	R3 04 ↓ MN 10/\$30 months 17,136.00 338.40 1,165.20 18,639.60 16,058.00
BC3/BR3 05 ↑ KS3 Kaiser Plan 4 Group #234480-00 Deductible \$0 OOP Max (Individual/Family) \$1,500/\$3,0 Office Visit Co-Pay \$30 Emergency Room \$100 / Ambulance \$ 100 Day Pharmacy (Generic/Brand) Hearing Aid \$500 / 1 per ear / 2 per Chiro \$10 co-pay/30 visits \$ 1,428 x 12 Months = Vision Service Plan C Delta Dental PPO Incentive Total Annual Premium	3/K 17 0 000 5 50 \$ 3 6 \$ \$ \$ \$ \$ \$ \$ \$	R3 04 ↓ MMN 10/\$30 months 17,136.00 338.40 1,165.20 18,639.60

It is my responsibility to complete a change form with Risk Management, within 30 days, for life events, i.e.:

Marriage/Divorce (marriage certificate/divorce papers required)

Birth/Adoption (birth certificate/adoption papers required)

Dependents are eligible for insurance until age 26 (birth certificate required)

Print Name/Signature

Date

Classification (circle one): MG / CN / NURSE / PSYCH / BD)

Social Security #

LANCASTER SCHOOL DISTRICT

2024-2025 HEALTH BENEFITS FOR MANAGEMENT/CONFIDENTIAL/NURSES/PSYCHOLOGISTS/BOARD (SISC)

The plan choices have changed. Select new plan if your plan is no longer available. Please make your selection by initialing in the box of your choice. Return to Risk Management by June 28, 2024. Your plan for the 2024-2025 school year will be effective October 1, 2024.

70% Two-Tiered HSA PPO Plan #70651B				
Deductible (Individual/Family) \$5,000/\$10,000				
OOP Max (Individual/Family) \$6,350/\$12,700				
Office Visit Co-Pay \$60 1st 3 visits, then deductible, then 30%				
Emergency Room/Ambulance \$100				
Hearing Aid \$700 / per 24 months				
30 Day Pharmacy (Generic/Brand) \$9/\$35 AFTER DE	D			
30 Day Costco (Generic/Brand) \$0/\$35 AFTER DED				
90 Day Costco (Generic/Brand) \$0/\$90 AFTER DED				
BC3/BR3 61				
SINGLE Rate Bronze Plan				
\$ 650 x 12 Months = \$ 7,800.	00			
Vision Service Plan C \$ 338.	40			
Delta Dental PPO Incentive \$ 1,165.	20			
Total Annual Premium \$ 9,303.	60			
Benefit Cap \$ 16,058.	00			
Difference \$ (6,754.	40)			
Monthly Payment \$-				
BC3/BR3 62				
EMPLOYEE + CHILD(REN) Rate Bronze Plan				
\$ 1,036 x 12 Months = \$ 12,432.	00			
Vision Service Plan C \$ 338.	40			
Delta Dental PPO Incentive \$ 1,165.	20			
Total Annual Premium \$ 13,935.	60			
Benefit Cap \$ 16,058.	00			
Difference \$ (2,122.	40)			
Monthly Payment \$-				

There is NO option to enroll a spouse/domestic partner

FOR OFFICE USE ONLY			
Dental #7079 7051 (DD3 01)	\$97.10/month		
Vision #0108350A (VS3 01)	\$28.20/month		
Medical/Dental/Vision CAP \$ Medical only CAP \$14,554.40 Medical only \$1,212.87/month	16,058		