

EASTSIDE UNION SCHOOL DISTRICT

2024/2025 CERTIFICATED HEALTH INSURANCE RATES

All changes are made through your MYCVT portal. All plan options include Delta Dental and EyeMed coverage.

PPO Plans

PLAN NUMBER	BLUE CROSS PPO 3A	BLUE CROSS PPO 5V	BLUE CROSS PPO 8V	BLUE CROSS PPO 9V	PPO Wellness
Individual/ Family Deductible(s):	Individual: \$100 Family: \$200	Individual: \$100 Family: \$200	Individual: \$500 Family: \$1,000	Individual: \$1,000 Family: \$2,000	Individual: \$500 Family: \$1,000
Co-Insurance:	Paid at 100% after deductible is met	Paid at 90% after deductible is met	Paid at 80% after deductible is met	Paid at 80% after deductible is met	Paid at 90% after deductible is met
Out-Of-Pocket Annual Max:	\$1,250 Ind/ \$2,500 Family	\$1,250 Ind/ \$2,500 Family	\$3,200 Ind/ \$6,500 Family	\$5,000 Ind/ \$10,000 Family	\$1,750 Ind/ \$3,500 Family
Doctors Visits:	\$20 co-payment	\$30 co-payment	\$30 co-payment	\$35 co-payment	\$20 co-payment
Emergency Room:	\$175 non-emergent co-pay/\$100 emergent co-pay	\$175 non-emergent co-pay/\$100 emergent co-pay	\$175 non-emergent co-pay/\$100 emergent co-pay	\$175 non-emergent co-pay/\$100 emergent co-pay	\$175 non-emergent co-pay/\$100 emergent co-pay
Prescription Retail:	\$5 generic/\$22 brand	\$0 generic/\$30 brand	\$0 generic/\$30 brand	\$0 generic/\$30 brand	\$7 generic/\$25 pref/\$40 non-pref
Mail Order:	\$10 generic/\$44 brand	\$0 generic/\$60 brand	\$0 generic/\$60 brand	\$0 generic/\$60 brand	\$15 generic/\$60 pref/\$90 non-pref

Dental 1	3D1	31A	5D1	51A	8D1	81A	9D1	91A	WD1	WA1
Monthly payroll deduction	Composite Rate: \$1,209.47 75% Rate: \$616.47		Composite Rate: \$1,008.47 75% Rate: \$465.47		Composite Rate: \$653.47 75% Rate: \$199.82		Composite Rate: \$448.47 75% Rate: \$45.47		Composite Rate: \$951.47 75% Rate: \$423.47	
Dental 2	3D2	32A	5D2	52A	8D2	82A	9D2	92A	WD2	WA2
Monthly payroll deduction	Composite Rate: \$1,298.73 75% Rate: \$705.73		Composite Rate: \$1,097.73 75% Rate: \$554.73		Composite Rate: \$742.73 75% Rate: \$288.73		Composite Rate: \$537.73 75% Rate: \$134.73		Composite Rate: \$1,040.73 75% Rate: \$512.73	

PLAN NUMBER	HDHP 2	Bronze Plan
Individual/ Family Deductible(s):	Individual: \$2,000 Family: \$4,000	Individual: \$5,000 Family: \$10,000
Co-Insurance Max:	Paid at 80% after deductible is met	Paid at 70% after deductible is met
Out-Of-Pocket Annual Max:	\$5,250 Ind/ \$10,500 Family	\$6,350 Ind/ \$12,700 Family
Doctors Visits:	Paid at 80% after deductible is met	Paid at 70% after deductible is met
Emergency Room:	Paid at 80% after deductible is met	\$60 co-pay
Prescription Retail:	Paid 80% after deductible is met	\$25 generic/\$50 brand
100 Day Fill:	Paid 80% after deductible is met	\$50 generic/\$100 brand

Dental 1	HD1	H1A	BD1	Z1A
Monthly payroll deduction	Composite Rate: \$104.47 75% Rate: \$0.00		Composite Rate: \$0.00 75% Rate: \$0.00	
Dental 2	HD2	H2A	BD2	Z2A
Monthly payroll deduction	Composite Rate: \$193.73 75% Rate: \$0.00		Composite Rate: \$81.73 75% Rate: \$0.00	

If you want to pre-tax your premiums, you are REQUIRED to complete an AFLAC ENROLLMENT FORM
(Salary redirection/Reduction Agreement)

1) 75% rate eligibility, all the following apply: 1. Spouse enrolled in a CVT PPO; 2. Both individuals cover each other as a dependent; 3. Both districts are on composite rates. If you qualify for the 75% rate, please notify Human Resources.

2) First 3 visits covered in full after \$60 co-pay per visit; remaining visits paid at 70% after deductible is met.

HMO Plans

PLAN NUMBER	KAISER 1 w/Chiro	KAISER 3 w/Chiro	KAISER 5 w/Chiro	KAISER 8 w/Chiro
Individual/ Family Deductible(s)	0	0	0	Individual: \$1,000 Family: \$2,000
Co-Insurance:	Paid at 100% after deductible is met	Paid at 100% after deductible is met	Paid at 100% after deductible is met	Paid at 100% after deductible is met
Out-Of-Pocket Annual Max:	\$1,500 Ind/ \$3,000 Family	\$1,500 Ind/ \$3,000 Family	\$1,500 Ind/ \$3,000 Family	\$3,000 Ind/ \$6,000 Family
Doctors Visits:	\$10 co-payment	\$20 co-payment	\$35 co-payment	\$20 co-payment
Emergency Room:	\$100 co-pay waived if admitted as in-patient	\$100 co-pay waived if admitted as in-patient	\$100 co-pay waived if admitted as in-patient	Paid at 80% after deductible is met
Prescription Retail:	\$5 generic/\$10 brand	\$10 generic/\$30 brand	\$10 generic/\$20 brand	\$10 generic/\$30 brand
100 Day Fill:	\$15 generic/\$30 brand	\$20 generic/\$60 brand	\$30 generic/\$60 brand	\$30 generic/\$90 brand

Dental 1	K11 1R1	K31 3R1		
Monthly payroll deduction	Composite Rate: \$434.86	Composite Rate: \$316.86	Composite Rate: \$266.86	Composite Rate: \$108.86
Dental 2	K12 1R2	K32 3R2		
Monthly payroll deduction	Composite Rate: \$524.12	Composite Rate: \$406.12	Composite Rate: \$356.12	Composite Rate: \$198.12

Vision Premiums are included in all plan options.

Dependents are eligible for insurance.

PLAN NUMBER	KAISER Wellness w/Chiro
Individual/ Family Deductible(s)	0
Co-Insurance:	Paid at 100% after deductible is met
Out-Of-Pocket Annual Max:	\$1,500 Ind/ \$3,000 Family
Doctors Visits:	\$20 co-payment primary/ \$40 Specialist
Emergency Room:	\$100 co-pay waived if admitted as in-patient
Prescription Retail:	\$30 generic/\$75 brand
100 Day Fill:	\$20 generic/\$50 brand

Dental 1	KW1 WK1
Monthly payroll deduction	Composite Rate: \$297.86
Dental 2	KW2 WK2
Monthly payroll deduction	Composite Rate: \$387.12

*Marriage/Divorce (marriage certificate/divorce decree required)

*Birth/Adoption (birth certificate/adoption papers required)

*Loss/Acquisition of coverage (documents required)

- Dental 1:

70/30 PPO, \$2,000 ANNUAL MAXIMUM, 4 CLEANINGS, NITROUS OXIDE
- Dental 2:

UNLIMITED ANNUAL MAXIMUM, 4 CLEANINGS, PROSTHODONTICS/IMPLANTS
70/80/90/100, NITROUS OXIDE, ORTHODONTICS ANULTS/CHILDREN \$4,000 MAXIMUM