Lakeport Unified School District

2020-2021 Classified Retiree Health Plan Enrollment Form

Medical Under 65	Plan 1 40693T	Plan 2 40693M	Plan 3 40693J	Plan 4 40693
Plan type	PPO Classic 90-A	PPO Classic 80-C	PPO Classic 80-G	HSA Minumum Value
Individual / Family deductible	$100/$300	$200/$500	$500/$1,000	$5,000/$10,000
Maximum Out of Pocket	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$6,350/$12,700
Coverage Level	90%	80%	80%	70%
Office Visit Co-pay	$20	$20	$30	Subject to Medical Deductible
Rx Co-pay Generic	Retail $10/Mail & Costco $0	Retail $10/Mail & Costco $0	Retail $10/Mail & Costco $0	Subject to Medical Deductible
Rx Co-pay Brand	Retail $35/Mail $90	Retail $35/Mail $90	Retail $35/Mail $90	Subject to Medical Deductible
Rx Brand Name Deductible	Indiv $200/ Family $500	Indiv $200/ Family $500	Indiv $200/ Family $500	Subject to Medical Deductible
Single	☐ 1,291.00	☐ 1,204.00	☐ 1,082.00	☐ 809.00
2- Party	☐ 1,806.00	☐ 1,686.00	☐ 1,519.00	☐ 1,108.00
Family	☐ 2,296.00	☐ 2,143.00	☐ 1,931.00	☐ 1,407.00

Over 65 Medical w/ A&B	Plan 5 4R005A	Plan 6 4R005G	Medicare Supplement Plan
Plan type	PPO Classic 100-A	PPO Classic 100-G	Companion Care PPO
Individual / Family deductible	$0/$0	$500/$1,00	
Maximum Out of Pocket	$1,000/$3,000	$1,000/$3,000	☐ 402.00 / per individual
Coverage Level	100%	100%	Enrollee Name: _____
Office Visit Co-pay	$0	$20	_____
Rx Co-pay Generic	Retail $0/Mail $0	Retail $0/Mail $0	
Rx Co-pay Brand	Retail $35/Mail $90	Retail $35/Mail $90	☐ 402.00 / per individual
Rx Brand Name Deductible	Indiv $200/ Family $500	Indiv $200/ Family $500	Enrollee Name: _____
Single	☐ 538.00	☐ 522.00	_____
2- Party	☐ 1,076.00	☐ 1,044.00	Please request enrollment forms 262-5534.
Family	☐ 1,424.00	☐ 1,376.00	Requires 45 day advance enrollment and must have A&B.

Delta Dental	
Annual Maximum	Unlimited
Orthodontia	None
Monthly Premium	
Single	☐ 83.00
2-Party	☐ 166.00
Family	☐ 218.00

Vision Service Plan	
Co-pay	$10 exam every 12 mo
	$25 materials every 12 mo
Monthly Premium	
Single	☐ 11.70
2-Party	☐ 23.40
Family	☐ 35.10

Total Monthly Premium Due: $ _____

I understand that the only time that I may change from one Blue Cross plan to another plan is during the district's designated open enrollment period. If I gain a new dependent (i.e. marriage, birth or adoption), I may add those dependents by completing a change form, however I cannot change from one plan to another at anytime except during the open enrollment period.

Name: _____ Signature: _____ Date: _____