# Lakeport Unified School District

## 2020-2021 Certificated Retiree Health Plan Enrollment Form

| Medical Under 65 | Plan 1 40693W | Plan 2 40693K | Plan 3 40693H | Plan 4 40693Q |
|---|---|---|---|---|
| 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 $5/Mail & Costco $0 | Retail $5/Mail & Costco $0 | Retail $10/Mail & Costco $0 | Subject to Medical Deductible |
| Rx Co-pay Brand | Retail $20/Mail $50 | Retail $20/Mail $50 | Retail $35/Mail $90 | Subject to Medical Deductible |
| Rx Brand Name Deductible | None | None | Indiv $200/ Family $500 | Subject to Medical Deductible |
| Single | ☐ 1,339.00 | ☐ 1,252.00 | ☐ 1,082.00 | ☐ 809.00 |
| 2- Party | ☐ 1,889.00 | ☐ 1,769.00 | ☐ 1,519.00 | ☐ 1,108.00 |
| Family | ☐ 2,402.00 | ☐ 2,249.00 | ☐ 1,931.00 | ☐ 1,407.00 |

| Over 65 Medical w/ A&B | Plan 5 4R001A | Plan 6 4R005G |
|---|---|---|
| Plan type | PPO Classic 100-A | PPO Classic 100-G |
| Individual / Family deductible | $0/$0 | $500/$1,000 |
| Maximum Out of Pocket | $1,000/$3,000 | $1,000/$3,000 |
| Coverage Level | 100% | 100% |
| Office Visit Co-pay | $0 | $20 |
| Rx Co-pay Generic | $0 | Retail $0/Mail $0 |
| Rx Co-pay Brand | $20 | Retail $35/Mail $90 |
| Rx Brand Name Deductible | $0 | Indiv $200/ Family $500 |
| Single | ☐ 586.00 | ☐ 522.00 |
| 2- Party | ☐ 1,172.00 | ☐ 1,044.00 |
| Family | ☐ 1,529.00 | ☐ 1,376.00 |

**Medicare Supplement Plan**

Companion Care PPO

☐ 402.00 / per individual

Enrollee Name: _____

_____

☐ 402.00 / per individual

Enrollee Name: _____

_____

Please request enrollment forms 262-5534.

Requires 45 day advance enrollment and must have A&B.

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

| Vision Service Plan | |
|---|---|
| Co-pay | $20 exam every 12 mo |
| | $25 materials every 12 mo |
| **Monthly Premium** | |
| Single | ☐ 10.40 |
| 2-Party | ☐ 20.80 |
| Family | ☐ 31.20 |

**Total Monthly Premium Due: $** _____

Name: _____ Signature: _____ Date: _____