

Employees will elect all benefits through <https://www.employeenavigator.com/benefits/Account/Login>. For questions, please contact Shelley Hanzen in HR. ([shanzen@cdaschools.org](mailto:shanzen@cdaschools.org) or 208-664-8241 x 10032)



This is only a summary and employees should always verify specific coverage with the Blue Cross Medical Insurance Summary in the Employee Navigator portal.

<b>Begin August 2022</b>	<b>Plan 1 "BUY UP" \$0 Deductible (In-Network)</b>	<b>Plan 2 "DRIVER" \$400 Deductible (In-Network)</b>
<b>DEDUCTIBLE (Calendar Year)</b> Individual Family	No Deductible	\$400 \$800
<b>OUT-OF-POCKET MAXIMUM (Calendar Year)</b> Individual Family	\$2,500 \$3,500	(Includes deductible) \$2,900 \$4,300
<b>COINSURANCE (In Network)</b>	Plan pays 100% Out-of-Network Services 50%	Plan pays 80% (After deductible is met up to out of pocket maximum)
<b>HOSPITALIZATION</b> Inpatient Outpatient	\$500 copay per admittance \$100 copay per facility	Deductible + 20% coinsurance
<b>MATERNITY</b>	\$200 copay \$500 copay for hospital admit.	Deductible + 20% coinsurance
<b>PRIMARY CARE PHYSICIAN VISIT</b> <b>NON-PRIMARY CARE PHYSICIAN VISIT</b>	\$20 Copay \$40 Copay	\$25 Copay \$40 Copay
<b>EMERGENCY ROOM</b>	\$75 Copay	\$100 Copay + deductible + 20% coins.
<b>CHIROPRACTIC</b>	\$40 Copay / visit (18 visit max)	Deductible + 20% coinsurance (18 visit max)
<b>PHYSICAL THERAPY OUTPATIENT</b>	\$40 Copay / visit (20 visit max)	Deductible + 20% coinsurance (20 visit max)
<b>DIAGNOSTIC LABS / IMAGING</b>	Covered 100%	First \$250.00 covered in full (100%) then deductible + 20% coinsurance
<b>PREVENTATIVE/WELLNESS CARE</b> <i>Pediatric Office Visits and Urgent Care for dependents under age 17.</i>	Covered at 100% \$0 copay	Covered at 100% \$0 copay
<b>CARDIAC REHAB. (OUTPATIENT)</b> <b>3D PREVENTIVE MAMMOGRAM</b>	Covered 100% after copay Covered 100%	Deductible + 20% Coinsurance (36 visits) Covered 100%
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>ELIGIBLE DEPENDENTS</b>	Up to age 26	Up to age 26
<b>PHARMACY / RX</b>	Approved Preventative Rx: Covered 100%	
<b>GENERIC PRESCRIPTIONS</b>	\$10 Copay (Deductible waived)	
<b>RX Deductible:</b> Preferred Brand Drugs Non-Preferred Brand Drugs Specialty	\$250 Rx Deductible (each member) After \$250 Rx Deductible, \$30 Copay After \$250 Rx Deductible, \$50 Copay After \$250 Rx Deductible, \$50 Copay	
<b>Rx Out of Pocket Maximum</b>	\$3,000 Individual / \$6,000 Family	
<b>HEALTH PLAN TIERS:</b>	<b>MONTHLY PREMIUMS *</b>	<b>MONTHLY PREMIUMS *</b>
<i>INCREASE FOR 2022/2023</i>	<i>@ 9.8% average increase</i>	<i>@ 9.8% average increase</i>
Employee	<b>\$ 740.45</b>	<b>\$ 638.90</b>
Employee + 1 child	<b>\$1,077.05</b>	<b>\$ 929.65</b>
Employee + 2 or more children	<b>\$1,365.25</b>	<b>\$1,177.90</b>
Employee + spouse	<b>\$1,628.90</b>	<b>\$1,406.05</b>
Family (Employee, spouse & child(ren))	<b>\$1,961.30</b>	<b>\$1,692.90</b>
<b>MONTHLY DISTRICT CONTRIBUTION</b>	<b>SEE BELOW*</b>	<b>\$1,151.17*</b>

*\*All employees who choose to enroll in Plan 1 and whose monthly premiums are lower than the monthly district contribution will pay the difference in premiums from Plan 2. The District Contribution is based on 68% of the family Plan 2 premium.*

**2022/23 DENTAL OPTIONS:** *You will not receive a card for dental coverage-it may show on your medical card if you elect the Blue Cross PPO or Dental Blue Connect (Willamette) option*

	Blue Cross Incentive PPO	Dental Blue Connect (Willamette)	Northwest Dental Benefits
<b>Provider Network</b>	BCI Dental PPO	Willamette Clinics Only	NW Dental Benefits Offices Only
<b>Deductible</b>	No Deductible	No Deductible	No Deductible
<b>Calendar Year Maximum</b>	\$1,250 Per Member	No Annual Maximum	\$2,500
<b>Diagnostic &amp; Preventive</b>	<i>Coverage based on member's incentive level:</i>	\$15 Office Visit Copay	
<b>Exams</b>	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
<b>Cleanings</b>	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
<b>Fluoride Treatment</b>	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
<b>X-Rays</b>	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
<b>Basic Services</b>			
<b>Fillings</b>	70% / 80% / 90% / 100%	\$15 Copay	\$20 Copay
<b>Simple Extractions</b>	70% / 80% / 90% / 100%	\$15 Copay	\$20 Copay
<b>Root Canals</b>	70% / 80% / 90% / 100%	\$50 Copay	\$200-\$300 Copay
<b>Major Services</b>			
<b>Crowns</b>	50%	\$150 Copay (per service, per tooth)	\$300 Copay (per service, per tooth)
<b>Bridges</b>	50%	\$150 Copay	\$300 Copay
<b>Dentures</b>	50%	\$200 Copay	\$500 Copay
<b>Complete Orthodontia</b>		\$1,500 Copay	\$2,000-\$2,500
Pre-Orthodontia Fee	N/A	\$150 Copay	Toward treatment
<b>Nitrous Oxide</b>	N/A	\$20 Copay	N/A
<b>Implant Benefit</b>	N/A	\$1,500 toward treatment	\$800 Copay (6 mo. waiting period)
	<b>BCI PPO Dental</b>	<b>Willamette</b>	<b>NW Dental</b>
<b>Rates</b>	Monthly Rates	Monthly Rates	Monthly Rates (6.25% increase from 21/22)
<b>Employee</b>	<b>\$41.70</b>	<b>\$59.49</b>	<b>\$42.18</b>
<b>Employee + 1</b>	<b>\$78.30</b>	<b>\$110.32</b>	<b>\$90.15</b>
<b>Employee + 2 or more</b>	<b>\$115.65</b>	<b>\$163.05</b>	<b>\$147.42</b>

**2022/23 VISION INSURANCE:** *United Heritage VSP (You will not receive a card for vision coverage)*

Network	CHOICE NETWORK	
Exam and Lenses – once every 12 months	\$10 copay for exam and \$25 copay for lenses (if not purchased with frames)	
Frames-once every 24 months/Contacts-once every 12 month	\$25 copay for \$130 allowance on materials (frames, lenses, contacts)	
<b>VISION PLAN TIERS:</b>	MONTHLY PREMIUMS / ( <i>Deduction in monthly check</i> )	
Employee only	<b>\$ 6.06</b>	-0-
Employee plus 1 or more children	<b>13.00</b>	(\$6.94)
Employee plus Spouse	<b>12.13</b>	(\$6.07)
Employee plus Spouse and children	<b>20.74</b>	(\$14.68)
<b>Monthly District Contribution</b>	<b>\$ 6.06</b>	

**This is only a summary and employees should always verify specific coverage with the Dental Insurance Summaries on the District website under the Human Resource Department and on the employeenavigator.com platform.**