Employees will elect all benefits through https://www.employeenavigator.com/benefits/Account/Login. For questions, please contact Shelley Hanzen in HR. (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.

Effective 9/1/2023	**Plan 1 "BUY UP"** **$0 Deductible (In-Network)**	**Plan 2 "DRIVER"** **$400 Deductible (In-Network)**
DEDUCTIBLE (Calendar Year) Individual Family	No Deductible	$400 $800
OUT-OF-POCKET MAXIMUM (Calendar Year) Individual Family	$2,500 $3,500	(Includes deductible) $2,900 $4,300
COINSURANCE (In Network)	Plan pays 100% Out-of-Network Services 50%	Plan pays 80% (After deductible is met up to out of pocket maximum)
HOSPITALIZATION Inpatient Outpatient	$500 copay per admittance $100 copay per facility	Deductible + 20% coinsurance
MATERNITY	$200 copay $500 copay for hospital admit.	Deductible + 20% coinsurance
PRIMARY CARE PHYSICIAN VISIT **NON-PRIMARY CARE PHYSICIAN VISIT**	$20 Copay $40 Copay	$25 Copay $40 Copay
EMERGENCY ROOM	$75 Copay	$100 Copay + deductible + 20% coins.
CHIROPRACTIC	$40 Copay / visit (18 visit max)	Deductible + 20% coinsurance (18 visit max)
PHYSICAL THERAPY OUTPATIENT	$40 Copay / visit (20 visit max)	Deductible + 20% coinsurance (20 visit max)
DIAGNOSTIC LABS / IMAGING	Covered 100%	First $250.00 covered in full (100%) then deductible + 20% coinsurance
PREVENTATIVE/WELLNESS CARE *Pediatric Office Visits and Urgent Care for dependents under age 17.*	Covered at 100% $0 copay	Covered at 100% $0 copay
CARDIAC REHAB. (OUTPATIENT) **3D PREVENTIVE MAMMOGRAM**	Covered 100% after copay Covered 100%	Deductible + 20% Coinsurance (36 visits) Covered 100%
LIFETIME MAXIMUM	Unlimited	Unlimited
ELIGIBLE DEPENDENTS	Up to age 26	Up to age 26
PHARMACY / RX	Approved Preventative Rx: Covered 100%	
GENERIC PRESCRIPTIONS	$10 Copay (Deductible waived)	
RX Deductible: 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	
Rx Out of Pocket Maximum	$3,000 Individual / $6,000 Family	
HEALTH PLAN TIERS:	**MONTHLY PREMIUMS ***	**MONTHLY PREMIUMS ***
INCREASE FOR 2023/2024	*@ 6.9% average increase*	*@ 6.9% average increase*
Employee	**$ 791.00** *($108.55 deduction/mo.)*	**$ 682.45**
Employee + 1 child	**$1,150.85** *($157.60 deduction/mo.)*	**$ 993.25**
Employee + 2 or more children	**$1,458.90**	**$1,258.65**
Employee + spouse	**$1,740.75**	**$1,502.55**
Family (Employee, spouse & child(ren))	**$2,096.10**	**$1,809.20**

MONTHLY DISTRICT CONTRIBUTION* **$1,230.26***

**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.*

2023/24 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
Provider Network	BCI Dental PPO	Willamette Clinics Only	NW Dental Benefits Offices Only
Deductible	No Deductible	No Deductible	No Deductible
Calendar Year Maximum	$1,250 Per Member	No Annual Maximum	$2,500
Diagnostic & Preventive	*Coverage based on member's incentive level:*	$15 Office Visit Copay	
Exams	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
Cleanings	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
Fluoride Treatment	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
X-Rays	70% / 80% / 90% / 100%	Covered 100%	Covered 100%
Basic Services			
Fillings	70% / 80% / 90% / 100%	$15 Copay	$25-$40 Copay
Simple Extractions	70% / 80% / 90% / 100%	$15 Copay	$35 Copay
Root Canals	70% / 80% / 90% / 100%	$50 Copay	$250-$400 Copay
Major Services			
Crowns	50%	$150 Copay (per service, per tooth)	$350-$400 Copay (per service, per tooth)
Bridges	50%	$150 Copay	$1,150 Copay
Dentures	50%	$200 Copay	$750 Copay
Complete Orthodontia Pre-Orthodontia Fee	N/A	$1,500 Copay $150 Copay	Up to $2,500 Lifetime benefit
Nitrous Oxide	N/A	$20 Copay	N/A
Implant Benefit	N/A	$1,500 toward treatment	$850 Copay (6 mo. waiting period)
	BCI PPO Dental	**Willamette**	**NW Dental**
Rates	Monthly Rates	Monthly Rates (3.73% increase from 22/23)	Monthly Rates (5% increase from 22/23)
Employee	**$41.70**	**$61.71**	**$44.29**
Employee + 1	**$78.30**	**$114.43**	**$94.66**
Employee + 2 or more	**$115.65**	**$169.13**	**$154.79**

2023/24 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 $130 allowance on materials (frames, lenses, contacts)	
VISION PLAN TIERS:	MONTHLY PREMIUMS / (*Deduction in monthly check)*	
Employee only	**$ 6.06**	*-0-*
Employee plus 1 or more children	**13.00**	*($6.94)*
Employee plus Spouse	**12.13**	*($6.07)*
Employee plus Spouse and children	**20.74**	*($14.68)*
Monthly District Contribution	**$ 6.06**	

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 in the employee benefits portal, Employee Navigator.
https://www.employeenavigator.com/benefits/Account/Login