CALIFORNIA'S VALUED TRUST (CVT) PPO PLAN OPTIONS

CLASSIFIED

Plan Year: October 1, 2026 - September 30, 2027

mycvt.trust.org
800-288-9870

Updated: 6/2026

MEDICAL PLAN OPTIONS

MONTHLY PREMIUM (Medical & Prescription)		3B	WELLNESS	8C	10D	HDHP-1	BRONZE	HDHP-3
		$3,041	$2,725	$2,402	$1,759	$1,828	$1,488	$1,371
CALENDAR YEAR DEDUCTIBLE	Per Individual	$100	$500	$500	$2,000	$1,700	$5,000	$6,500
	Per Family	$200	$1,000	$1,000	$4,000	$3,400	$10,000	$13,000
COPAY	Your cost after deductible is met	0%	10%	20%	20%	10%	30%	30%
CALENDAR YEAR OUT - OF - POCKET MAXIMUM	Per Individual	$2,500	$3,500	$4,500	$6,500	$5,000	$7,000	$8,000
	Per Family	$5,000	$7,000	$9,000	$13,000	$10,000	$14,000	$16,000
	Per individual in a family	$2,500	$3,500	$4,500	$6,500	$5,000	$7,000	$8,000
OFFICE VISIT COPAY	Primary Care	$20	$20	$30	paid at 80% after deductible is met	paid at 90% after deductible is met	$60 copay for first 3 visits-Remaining visits paid at 70% after deductive is met.	Subject to deductible then $60 copay per visit.
	Specialty Care	$40	$40	$60	paid at 80% after deductible is met	paid at 90% after deductible is met	Subject to deductible then $120 per visit.	Subject to deductible then $120 per visit.
HOSPITAL EMERGENCY ROOM COPAY		$200 (waived if admitted as patient) After copay, paid at 100%	$200 (waived if admitted as patient) After deductible met, copay then paid at 90%	$200 (waived if admitted as patient) After deductible met, copay then paid at 80%	$200 (waived if admitted as patient) After deductible met, copay then paid at 80%	Paid at 90% after deductible is met	Subject to Deductible, then $200 Copay (waived if admitted as inpatient)	Paid at 70% after deductible is met

PRESCRIPTION PLANS

Prescription plans are paired with a medical plan as listed above	B		C / WELLNESS		D		HDHP-1/BRONZE/HDHP-3	
	30 Day Supply Retail	90 Day Supply Mail Order	30 Day Supply Retail	90 Day Supply Mail Order	30 Day Supply Retail	90 Day Supply Mail Order	30 Day Supply Retail	90 Day Supply Mail Order
					$150 Brand Deductible		After Deductible is Met	
Generic	$7	$15	$7	$15	$10	$25	$25	$50
Preferred Brand Name	$15	$35	$25	$60	$40	$100	$50	$100
Non-Preferred Brand Name	$30	$70	$40	$90	$100	$250	$50	$100
Specialty *(Paid @ $0 when enrolled in Prudent RX)*	Paid @ 70%	N/A	Paid @ 70%	N/A	Paid @ 70%	N/A	Paid @ 70%	N/A

DISTRICT & EMPLOYEE COST

Certificated employees pay insurance premium contributions are taken one month in advance.

PLAN CHOICES	3B	WELLNESS	8C	10D	HDHP-1	BRONZE	HDHP-3
Medical/Prescription Monthly Cost	$3,041.00	$2,725.00	$2,402.00	$1,759.00	$1,828.00	$1,488.00	$1,371.00
Vision Plan B - $15.00 Copay Monthly Cost	$16.99	$16.99	$16.99	$16.99	$16.99	$16.99	$16.99
Dental Unlimited Monthly Cost	$127.79	$127.79	$127.79	$127.79	$127.79	$127.79	$127.79
Total Monhtly Cost for Medical/Vision/Dental	$3,185.78	$2,869.78	$2,546.78	$1,903.78	$1,972.78	$1,632.78	$1,515.78
Total Annual Cost for Medical/Vision/Dental	$38,229.36	$34,437.36	$30,561.36	$22,845.36	$23,673.36	$19,593.36	$18,189.36
Less District Annual Contriubtion ($10,711.52)	*($10,711.52)*	*($10,711.52)*	*($10,711.52)*	*($10,711.52)*	*($10,711.52)*	*($10,711.52)*	*($10,711.52)*
Total Annual Cost to Employee per Plan	*$27,517.84*	*$23,725.84*	*$19,849.84*	*$12,133.84*	*$12,961.84*	*$8,881.84*	*$7,477.84*
Monthly Cost for Medical/Vision/Dental per Plan	**$2,293.15**	**$1,977.15**	**$1,654.15**	**$1,011.15**	**$1,080.15**	**$740.15**	**$623.15**