2026-2027 Certificated Health Insurance Rates
FOR ALL TAL UNIT MEMBERS

Open Enrollment Period is July 27th, 2026 - August 21st, 2026. Return to Risk Management by August 21st, 2026.

Please make your selection by initialing through the box of your plan choice. Your selection for the 2026-2027 plan year will be effective October 1, 2026.

You must complete a form whether or not you are making a change. For plan changes, you must also go to mycvt.cvtrust.org to indicate your new plan selection.

BCI/BCR 11

BLUE CROSS 100% Plan 1A #13929A	
Deductible	$0
OOP Max	$1500 ind / $3000 family
Office Visit Co-Pay	$10 primary/$20 specialist
ER $200	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Brand) $5/$22 90 Day RX mail order $10/$44	
$ 3,155 x 12 Months =	$ 37,860.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 39,531.84
Benefit Cap	$ 16,058.00
Difference	$ 23,473.84
Monthly Payment	$ 1,956.16

BCI/BCR 01

BLUE CROSS 100% Plan 3A #13929C	
Deductible	$100 ind/$200 family
OOP Max	$2500 ind / $5000 family
Office Visit Co-Pay	$20 primary/$40 specialist
ER $200	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Brand) $5/$22 90 Day RX mail order $10/$44	
$ 2,914 x 12 Months =	$ 34,968.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 36,639.84
Benefit Cap	$ 16,058.00
Difference	$ 20,581.84
Monthly Payment	$ 1,715.16

BCT/BRT 01

BLUE CROSS 90% Plan 4B #13929D	
Deductible	$150 ind/$300 family
OOP Max	$2500 ind / $5000 family
Office Visit Co-Pay	$20 primary/$40 specialist
ER $200	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Preferred/Non-Preferred) $7/$15/$30 90 day RX mail order $15/$35/$70	
$ 2,784 x 12 Months =	$ 33,408.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 35,079.84
Benefit Cap	$ 16,058.00
Difference	$ 19,021.84
Monthly Payment	$ 1,585.16

BCI/BCR 41

BLUE CROSS 90% Plan WELLNESS #1841NA	
Deductible	$500 ind/$1000 family
OOP Max	$3500 ind / $7000 family
Office Visit Co-Pay	$20 primary/$40 specialist
ER $200	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Preferred/Non-Preferred) $7/$25/$40 90 Day RX mail order $15/$60/$90	
$ 2,598 x 12 Months =	$ 31,176.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 32,847.84
Benefit Cap	$ 16,058.00
Difference	$ 16,789.84
Monthly Payment	$ 1,399.16

BCT/BRT 11

BLUE CROSS 80% Plan 7C #13929G	
Deductible	$300 ind/$600 family
OOP Max	$3500 ind / $7000 family
Office Visit Co-Pay	$30 primary/$60 specialist
ER $200	
Outpatient Hospital - Laboratory $50/Radiology $75/Surgery $250	
30 Day RX (Generic/Preferred/Non-Preferred) $7/$25/$40 90 day RX mail order $15/$60/$90	
$ 2,511 x 12 Months =	$ 30,132.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 31,803.84
Benefit Cap	$ 16,058.00
Difference	$ 15,745.84
Monthly Payment	$ 1,312.16

BCT/BRT 21

BLUE CROSS 90% PPO HDHP 1 #13931N	
Deductible	$1700 ind/$3400 family no ind limit applies to family
OOP Max	$5000 ind/$10000 family
Office Visit Co-Pay	90% after deductible
Emergency Room	90% after deductible
Prescription Drugs - Major Medical * * subject to Deductible then $25/$50	
$ 1,743 x 12 Months =	$ 20,916.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 22,587.84
Benefit Cap	$ 16,058.00
Difference	$ 6,529.84
Monthly Payment	$ 544.16

BCT/BRT 41

CVT 70% Bronze Plan PPO #1853YA	
Deductible	$5000 ind/$10000 family Emergency/Urgent care See SBC
OOP Max	$7000 ind / $14000 family
Office Visit Co-Pay	$60 (1st 3) then 70% after deductible
Specialist Visit Co-Pay	deductible then $120
30 Day RX Sub. to deductible then $25/$50 (Generic/Brand) 90 Day RX Sub. to deductible then $50/$100 (Generic/Brand)	
$ 1,420 x 12 Months =	$ 17,040.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 18,711.84
Benefit Cap	$ 16,058.00
Difference	$ 2,653.84
Monthly Payment	$ 221.16

BCT/BRT 31

Blue Shield HMO 2 100% Plan #H55709	
Deductible	$0
OOP Max	$1500 ind / $3000 family
Office Visit Co-Pay	$15 primary/$30 specialist
Emergency/Ambulance	$100
30 Day RX (Generic/Formulary/Non-Formulary) $7/$15/$30 90 day RX mail order $15/$35/$70	
$ 2,974 x 12 Months =	$ 35,688.00
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 37,359.84
Benefit Cap	$ 16,058.00
Difference	$ 21,301.84
Monthly Payment	$ 1,775.16

DENTAL AND VISION PREMIUMS INCLUDED IN ALL MEDICAL PLANS

Delta Dental PPO Premier Incentive #7901-2011
$1900 max, 2 cleanings per year, Ortho 50/50 $500 lifetime

Vision Service Plan C #2025584A
$5/$20 co-pay, $200 frame/ $150 contact allotment

- Dependents are eligible for insurance until age 26

- The first deduction will come out of the September check. If a deduction does not come out of a check, it is your responsibility to contact Risk Management to make payment arrangements.

2026-2027 Certificated Health Insurance Rates - FOR ALL TAL UNIT MEMBERS

Initial through the box of your plan choice. Return by August 21st, 2026.

KS1/KR1 01

Kaiser 1 w/ Chiro #0406-0000C	
Office Visit Co-Pay	$10
OOP Max	$1500 ind / $3000 family
Emergency Room	$100
Chiropractic	$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) $5/$10 100 day RX mail order $10/$20	
$ 1,731.39 x 12 Months =	$ 20,776.68
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 22,448.52
Benefit Cap	$ 16,058.00
Difference	$ 6,390.52
Monthly Payment	$ 532.55

KS1/KR1 02

Kaiser 2 w/ Chiro #0406-0037C	
Office Visit Co-Pay	$15
OOP Max	$1500 ind / $3000 family
Emergency Room	$100
Chiropractic	$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) $5/$10 100 day RX mail order $10/$20	
$ 1,681.39 x 12 Months =	$ 20,176.68
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 21,848.52
Benefit Cap	$ 16,058.00
Difference	$ 5,790.52
Monthly Payment	$ 482.55

KS1/KR1 03

Kaiser 3 w/ Chiro #0406-0040C	
Office Visit Co-Pay	$20
OOP Max	$1500 ind / $3000 family
Emergency Room	$100
Chiropractic	$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) $10/$20 100 day RX mail order $20/$40	
$ 1,604.39 x 12 Months =	$ 19,252.68
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 20,924.52
Benefit Cap	$ 16,058.00
Difference	$ 4,866.52
Monthly Payment	$ 405.55

KS1/KR1 09

Kaiser Wellness w/ Chiro #0406-0375C	
Office Visit Co-Pay	$20 primary/$40 specialist
OOP Max	$1500 ind / $3000 family
Emergency Room	$100
Ambulance	$100
Outpatient/Inpatient Hospitalization	$500
Chiropractic	$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) $10/$25 100 day RX mail order $20/$50	
$ 1,597.39 x 12 Months =	$ 19,168.68
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 20,840.52
Benefit Cap	$ 16,058.00
Difference	$ 4,782.52
Monthly Payment	$ 398.55

KS1/KR1 07

Kaiser 7 WITH Chiro #0406-0052C	
Office Visit Co-Pay	$35
OOP Max	$1500 ind / $3000 family
Emergency Room / Ambulance	$100
Outpatient/Inpatient Hospitalization	$250
Durable Medical Equipment - Paid at	80%
Chiropractic	$10 co-pay / 40 visits
30 Day Pharmacy (Generic/Brand) $10/$30 100 day RX mail order $20/$60	
$ 1,527.39 x 12 Months =	$ 18,328.68
Vision Service Plan C	$ 338.28
Delta Dental Premier Incentive PPO	$ 1,333.56
Total Annual Premium	$ 20,000.52
Benefit Cap	$ 16,058.00
Difference	$ 3,942.52
Monthly Payment	$ 328.55

Plan summaries available in Risk Management or www.lancsd.org

FOR OFFICE USE ONLY
DD1/DR1 01 $111.13/month
VSP/VIR 01 $28.19/month
Medical/Dental/Vision Cap $16,058
M Only Cap (16,058-1,333.56-338.28) = $14,386.16
District = $1,198.84/month

I understand that it is my responsibility to update MyCVT, **within 30 days**, for any life event, i.e.:

- Marriage/Divorce (marriage license/certificate/divorce decree required)
- Birth/Adoption (birth certificate/adoption papers required)
- Loss/Acquisition of coverage (documentation required)

Print Name _____ Signature _____ Social Security # _____ School Site _____ Date _____

□ Check here if your spouse is employed with the LANCASTER SCHOOL DISTRICT or with ANOTHER SCHOOL DISTRICT & ENROLLED IN CVT INSURANCE (ON A COMPOSITE RATE), and complete spouse information below.

Spouse's Name _____ Spouse's School District _____