

2025-2026 Certificated Health Insurance Rates  
FOR ALL TAL UNIT MEMBERS

**Open Enrollment Period is August 8th, 2025- August 29th, 2025. Return to Risk Management by August 29th, 2025.**

Please make your selection by **initialing through** the box of your **plan choice**. Your selection for the 2025-2026 plan year will be effective October 1, 2025.

**You must complete a form whether or not you are making a change. For plan changes, you must also go to [mycvf.cvtrust.org](http://mycvf.cvtrust.org) to indicate your new plan selection.**

**BCI/BCR 11**

<b>BLUE CROSS 100% Plan 1A #13929A</b>	
Deductible	\$0
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$10
ER	\$150
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Brand) \$5/\$22	
90 Day RX mail order \$10/\$44	
\$ 2,920 x 12 Months =	\$ 35,040.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 36,711.84
Benefit Cap	\$ 16,058.00
Difference	\$ 20,653.84
<b>Monthly Payment</b>	<b>\$ 1,721.16</b>

**BCI/BCR 01**

<b>BLUE CROSS 100% Plan 3A #13929C</b>	
Deductible	\$100 ind/\$200 family
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$20
ER	\$150
Outpatient Hospital - Laboratory \$50/Radiology \$75/Surgery \$250	
30 Day RX (Generic/Brand) \$5/\$22	
90 Day RX mail order \$10/\$44	
\$ 2,697 x 12 Months =	\$ 32,364.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 34,035.84
Benefit Cap	\$ 16,058.00
Difference	\$ 17,977.84
<b>Monthly Payment</b>	<b>\$ 1,498.16</b>

**BCT/BRT 01**

<b>BLUE CROSS 90% Plan 4B #13929D</b>	
Deductible	\$100 ind/\$200 family
OOP Max	\$1250 ind / \$2500 family
Office Visit Co-Pay	\$20
ER	\$150
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	
\$ 2,578 x 12 Months =	\$ 30,936.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 32,607.84
Benefit Cap	\$ 16,058.00
Difference	\$ 16,549.84
<b>Monthly Payment</b>	<b>\$ 1,379.16</b>

**BCI/BCR 41**

<b>BLUE CROSS 90% Plan WELLNESS #1841NA</b>	
Deductible	\$500 ind/\$1000 family
OOP Max	\$1750 ind / \$3500 family
Office Visit Co-Pay	\$20 primary/\$40 specialist
ER	\$150
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	
\$ 2,406 x 12 Months =	\$ 28,872.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 30,543.84
Benefit Cap	\$ 16,058.00
Difference	\$ 14,485.84
<b>Monthly Payment</b>	<b>\$ 1,207.16</b>

**BCT/BRT 11**

<b>BLUE CROSS 80% Plan 7C #13929G</b>	
Deductible	\$250 ind/\$500 family
OOP Max	\$2000 ind / \$4000 family
Office Visit Co-Pay	\$30
ER	\$150
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	
\$ 2,326 x 12 Months =	\$ 27,912.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 29,583.84
Benefit Cap	\$ 16,058.00
Difference	\$ 13,525.84
<b>Monthly Payment</b>	<b>\$ 1,127.16</b>

**BCT/BRT 21**

<b>BLUE CROSS 90% PPO HDHP 1 #13931N</b>	
Deductible	\$1700 ind/\$3400 family <small>no ind limit applies to family</small>
OOP Max	\$5000 ind/\$10000 family
Office Visit Co-Pay	Major Medical *
Emergency Room	Major Medical *
Prescription Drugs - Major Medical *	
* subject to Deductible then \$25/\$50	
\$ 1,614 x 12 Months =	\$ 19,368.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 21,039.84
Benefit Cap	\$ 16,058.00
Difference	\$ 4,981.84
<b>Monthly Payment</b>	<b>\$ 415.16</b>

**BCT/BRT 41**

<b>CVT 70% Bronze Plan PPO #1853YA</b>	
Deductible	\$5000 ind/\$10000 family
OOP Max	\$7000 ind / \$14000 family
Office Visit Co-Pay	See SBC
Emergency/Urgent Care	See SBC
30 Day RX Sub. to deductible then \$25/\$50 (Generic/Brand)	
90 Day RX Sub. to deductible then \$50/\$100 (Generic/Brand)	
\$ 1,315 x 12 Months =	\$ 15,780.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 17,451.84
Benefit Cap	\$ 16,058.00
Difference	\$ 1,393.84
<b>Monthly Payment</b>	<b>\$ 116.16</b>

**BCT/BRT 31**

<b>Blue Shield HMO 2 100% Plan #H55709</b>	
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	
\$ 2,724 x 12 Months =	\$ 32,688.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 34,359.84
Benefit Cap	\$ 16,058.00
Difference	\$ 18,301.84
<b>Monthly Payment</b>	<b>\$ 1,525.16</b>

**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.

**2025-2026 Certificated Health Insurance Rates - FOR ALL TAL UNIT MEMBERS**  
**Initial through the box of your plan choice. Return by August 29th, 2025.**

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	
\$ 1,634.39 x 12 Months =	\$ 19,612.68
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 21,284.52
Benefit Cap	\$ 16,058.00
Difference	\$ 5,226.52
Monthly Payment	\$ 435.55

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	
\$ 1,587.39 x 12 Months =	\$ 19,048.68
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 20,720.52
Benefit Cap	\$ 16,058.00
Difference	\$ 4,662.52
Monthly Payment	\$ 388.55

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	
\$ 1,514.39 x 12 Months =	\$ 18,172.68
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 19,844.52
Benefit Cap	\$ 16,058.00
Difference	\$ 3,786.52
Monthly Payment	\$ 315.55

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	
\$ 1,494.39 x 12 Months =	\$ 17,932.68
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 19,604.52
Benefit Cap	\$ 16,058.00
Difference	\$ 3,546.52
Monthly Payment	\$ 295.55

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	
\$ 1,441.39 x 12 Months =	\$ 17,296.68
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 18,968.52
Benefit Cap	\$ 16,058.00
Difference	\$ 2,910.52
Monthly Payment	\$ 242.55

Plan summaries available in Risk Management or [www.lancsd.org](http://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	= \$1,198.85/month

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

- Marriage/Divorce (marriage 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