LANCASTER SCHOOL DISTRICT

2026-2027 HEALTH BENEFITS FOR MANAGEMENT/CONFIDENTIAL/NURSES/PSYCHOLOGISTS/BOARD (SISC) **SPOUSE RATES**

The plan options have changed this year. Please make your selection by initialing in the box of your choice.

Return to Risk Management by **June 30, 2026**. Your plan for the 2026-2027 school year will be effective October 1, 2026.

BLUE CROSS 100% Plan B Group #40026B	
Deductible (Individual/Family)	$500/$1000
OOP Max (Individual/Family)	$1,000/$3,000
Rx OOP Max (Individual/Family)	$2,500/$3,500
Office Visit Co-Pay	$20 (first 3 visits free)
Emergency Room/Ambulance	$100
30 Day Pharmacy (Generic/Brand)	$9/$35
30 Day Costco (Generic/Brand)	$0/$35
90 Day Costco (Generic/Brand)	$0/$90
$ 1,500.75 x 12 Months =	$ 18,009.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 19,512.60
Benefit Cap	$ 16,058.00
Difference	$ 3,454.60
Monthly Payment	$ 287.89

BC3/BR3 28 ↑

BLUE CROSS 90% Plan C Group # 40651D	
Deductible (Individual/Family)	$200/$500
OOP Max (Individual/Family)	$1,000/$3,000
Rx OOP Max (Individual/Family)	$2,500/$3,500
Office Visit Co-Pay	$20 (first 3 visits free)
Emergency Room/Ambulance	$100
30 Day Pharmacy (Generic/Brand)	$9/$35
30 Day Costco (Generic/Brand)	$0/$35
90 Day Costco (Generic/Brand)	$0/$90
$ 1,485.00 x 12 Months =	$ 17,820.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 19,323.60
Benefit Cap	$ 16,058.00
Difference	$ 3,265.60
Monthly Payment	$ 272.14

BC3/BR3 33 ↑

BLUE CROSS 80% Plan E Group # 40651E	
Deductible (Individual/Family)	$300/$600
OOP Max (Individual/Family)	$1,000/$3,000
Rx OOP Max (Individual/Family)	$2,500/$3,500
Office Visit Co-Pay	$20 (first 3 visits free)
Emergency Room/Ambulance	$100
30 Day Pharmacy (Generic/Brand)	$9/$35
30 Day Costco (Generic/Brand)	$0/$35
90 Day Costco (Generic/Brand)	$0/$90
$ 1,389.00 x 12 Months =	$ 16,668.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 18,171.60
Benefit Cap	$ 16,058.00
Difference	$ 2,113.60
Monthly Payment	$ 176.14

BC3/BR3 55 ↑

DIAMOND (PREVIOUSLY NAMED PLATINUM +) #M223	
Deductible (Individual/Family)	$0
OOP Max (Individual/Family)	$1,000/$3,000
Rx OOP Max (Individual/Family)	$0
Office Visit Co-Pay PCP	$0 Specialist $40
Emergency Room/Ambulance	$300
30 Day Pharmacy (Generic/Brand)	$9/$35
30 Day Costco (Generic/Brand)	$0/$35
90 Day Costco (Generic/Brand)	$0/$90
$ 1,485.00 x 12 Months =	$ 17,820.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 19,323.60
Benefit Cap	$ 16,058.00
Difference	$ 3,265.60
Monthly Payment	$ 272.14

BC3/BR3 77 ↑

KS3/KR3 23 ↓

Kaiser Plan 3 Group #234480-0015AMN	
Deductible	$0
OOP Max (Individual/Family)	$1,500/$3,000
Office Visit Co-Pay	$10
Emergency Room $100 / Ambulance	$50
100 Day Pharmacy (Generic/Brand)	$10
Hearing Aid	$500 / 1 per ear / 2 per 36 months
Chiro $10 co-pay/30 visits	
$ 1,279.50 x 12 Months =	$ 15,354.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 16,857.60
Benefit Cap	$ 16,058.00
Difference	$ 799.60
Monthly Payment	$ -

KS3/KR3 25 ↓

Kaiser Plan 5 Group #234480-0137ABN	
Deductible	$0
OOP Max (Individual/Family)	$1,500/$3,000
Office Visit Co-Pay	$20
Emergency Room $100 / Ambulance	$50
30 Day Pharmacy (Generic/Brand)	$10/$30
Hearing Aid	$500 / 1 per ear / 2 per 36 months
Chiro $10 co-pay/30 visits	
$ 1,223.25 x 12 Months =	$ 14,679.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 16,182.60
Benefit Cap	$ 16,058.00
Difference	$ 124.60
Monthly Payment	$ -

KS3/KR3 26 ↓

Kaiser Plan 6 Group #234480-0139ABN	
Deductible	$0
OOP Max (Individual/Family)	$1,500/$3,000
Office Visit Co-Pay	$30
Emergency Room $100 / Ambulance	$50
30 Day Pharmacy (Generic/Brand)	$10/$30
Hearing Aid	$500 / 1 per ear / 2 per 36 months
Chiro $10 co-pay/30 visits	
$ 1,209.75 x 12 Months =	$ 14,517.00
Vision Service Plan C	$ 338.40
Delta Dental PPO Incentive	$ 1,165.20
Total Annual Premium	$ 16,020.60
Benefit Cap	$ 16,058.00
Difference	$ (37.40)
Monthly Payment	$ -

PREVIOUSLY NAMED KAISER 4

It is my responsibility to complete a change form with Risk Management, **within 30 days**, for life events, i.e.:

Marriage/Divorce (marriage licence/certificate/divorce papers required)

Birth/Adoption (birth certificate/adoption papers required)

Dependents are eligible for insurance until age 26 (birth certificate required)

_____ _____

Print Name/Signature Date

_____

Social Security #

Classification (circle one):

MG / CN / NURSE / PSYCH / BD)

LANCASTER SCHOOL DISTRICT

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70% Two-Tiered HSA PPO Plan #70651B	
Deductible (Individual/Family)	$5,000/$10,000
OOP Max (Individual/Family)	$6,350/$12,700
Office Visit Co-Pay	$60 1st 3 visits, then deductible, then 30%
Emergency Room/Ambulance	$100
Hearing Aid	$700 / per 24 months
30 Day Pharmacy (Generic/Brand)	$9/$35 AFTER DED
30 Day Costco (Generic/Brand)	$0/$35 AFTER DED
90 Day Costco (Generic/Brand)	$0/$90 AFTER DED

BC3/BR3 61

SINGLE Rate Bronze Plan		
$ 684 x 12 Months =	$	8,208.00
Vision Service Plan C	$	338.40
Delta Dental PPO Incentive	$	1,165.20
Total Annual Premium	$	9,711.60
Benefit Cap	$	16,058.00
Difference	$	(6,346.40)
Monthly Payment	$	-

BC3/BR3 62

EMPLOYEE + CHILD(REN) Rate Bronze Plan		
$ 1,090 x 12 Months =	$	13,080.00
Vision Service Plan C	$	338.40
Delta Dental PPO Incentive	$	1,165.20
Total Annual Premium	$	14,583.60
Benefit Cap	$	16,058.00
Difference	$	(1,474.40)
Monthly Payment	$	-

There is NO option to enroll a spouse/domestic partner

FOR OFFICE USE ONLY	
Dental #7079 7051 (DD3 01)	$97.10/month
Vision #0108350A (VS3 01)	$28.20/month
Medical/Dental/Vision CAP $16,058	
Medical only CAP $14,554.40	
Medical only $1,212.86/month	