CALIFORNIA'S VALUED TRUST (CVT) PPO PLAN OPTIONS

CERTIFICATED RETIREES UNDER 65 (Not Medicare eligible)

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

mycvt.trust.org
800-288-9870

Updated: 6/4/2026

MEDICAL PLAN OPTIONS

MEDICAL & PRESCRIPTION PLANS		1A	4A	WELLNESS	8A	10D	BRONZE	HDHP-3
PREMIUM COST	Single	$2,343	$2,091	$1,935	$1,762	$1,258	$1,003	$926
	Couple	$4,031	$3,597	$3,328	$3,031	$2,164	$1,726	$1,593
	Family	$5,085	$4,538	$4,198	$3,824	$2,732	$2,178	$2,010
CALENDAR YEAR DEDUCTIBLE	Single	$0	$150	$500	$500	$2,000	$5,000	$6,500
	Couple	$0	$300	$1,000	$1,000	$4,000	$10,000	$13,000
	Family	$0	$300	$1,000	$1,000	$4,000	$10,000	$13,000
COPAY	Your cost after deductible is met	0%	10%	10%	20%	20%	30%	30%
CALENDAR YEAR OUT - OF - POCKET MAXIMUM	Per Individual	$1,500	$2,500	$3,500	$4,500	$6,500	$7,000	$8,000
	Per Family	$3,000	$5,000	$7,000	$9,000	$13,000	$14,000	$16,000
	Per individual in a family	$1,500	$2,500	$3,500	$4,500	$6,500	$7,000	$8,000
OFFICE VISIT COPAY	Primary Care	$10	$20	$20	$30	paid at 80% 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	$20	$40	$40	$60	paid at 80% 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 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%	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	A		WELLNESS		D		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	$5	$10	$7	$15	$10	$25	$25	$50
Preferred Brand	$22	$44	$25	$60	$40	$100	$50	$100
Non-Preferred Brand	$22	$44	$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

VISION & DENTAL	SINGLE	COUPLE	FAMILY	DISTRICT ANNUAL CONTRIBUTION
Vision C ($15 Copay/2nd Set of Eyewear-$20 Deductible) Monthly Cost	$14.84	$27.56	$42.43	$11,004.80
Dental Unlimited Monthly Cost	$69.62	$126.09	$181.27	

**** Please contact Business Services Department at cusdbusiness@colusa.k12.ca.us for couple rates if one member is the age of 65+***