

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

Open Enrollment Period is July 27th, - 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 mycvtrust.org to indicate your new plan selection.

BCI/BCR 12

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	
\$ 2,367 x 12 Months =	\$ 28,404.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 30,075.84
Benefit Cap	\$ 16,058.00
Difference	\$ 14,017.84
Monthly Payment	\$ 1,168.16

BCI/BCR 02

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	
\$ 2,186 x 12 Months =	\$ 26,232.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 27,903.84
Benefit Cap	\$ 16,058.00
Difference	\$ 11,845.84
Monthly Payment	\$ 987.16

BCT/BRT 02

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	
\$ 2,088 x 12 Months =	\$ 25,056.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 26,727.84
Benefit Cap	\$ 16,058.00
Difference	\$ 10,669.84
Monthly Payment	\$ 889.16

BCI/BCR 42

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	
\$ 1,949 x 12 Months =	\$ 23,388.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 25,059.84
Benefit Cap	\$ 16,058.00
Difference	\$ 9,001.84
Monthly Payment	\$ 750.16

BCT/BRT 12

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	
\$ 1,884 x 12 Months =	\$ 22,608.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 24,279.84
Benefit Cap	\$ 16,058.00
Difference	\$ 8,221.84
Monthly Payment	\$ 685.16

BCT/BRT 22

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 *	
* paid at 90% after deductible is met	
\$ 1,308 x 12 Months =	\$ 15,696.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 17,367.84
Benefit Cap	\$ 16,058.00
Difference	\$ 1,309.84
Monthly Payment	\$ 109.16

BCT/BRT 42

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)	
\$ 1,065 x 12 Months =	\$ 12,780.00
Vision Service Plan C	\$ 338.28
Delta Dental Premier Incentive PPO	\$ 1,333.56
Total Annual Premium	\$ 14,451.84
Benefit Cap	\$ 16,058.00
Difference	\$ (1,606.16)
Monthly Payment	\$ -

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 - **SPOUSE RATES**

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.