# VCSBSA

## 2025-2026 CALCULATE YOUR COST WORKSHEET

| | | COLUMN A | COLUMN B |
|---|---|---|---|
| | | 7/1/25 - 9/30/25 | 10/1/25- 6/30/26 |
| | **FULL-TIME ANNUAL CAP *** | | |
| | | **COST** 7/1/25 - 9/30/25 | **COST** 10/1/25 - 6/30/26 |
| | **ANTHEM BLUE CROSS PPO PLAN: PBC 100%-D** | Single | Single |
| Medical | $300/$600 ded, $1,000/$3,000 out-of-pocket max, $20 co-pay office visit | $ 970.50 | $ 1,050.50 |
| RX (Prescriptions) | Navitus 9-35 | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,892.00 | $ 2,046.00 |
| Ortho | None | Family | Family |
| Vision | Plan C, Dual Co-pay, $20/$25 | $ 2,652.50 | $ 2,869.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **ANTHEM BLUE CROSS PPO PLAN: PBC 80%-G** | Single | Single |
| Medical | $500/$1,000 ded, $2000/$4000 out-of-pocket max, $20 co-pay office visit | $ 839.50 | $ 908.50 |
| RX (Prescriptions) | Navitus 9-35 | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,629.00 | $ 1,762.00 |
| Ortho | None | Family | Family |
| Vision | Plan C, Dual Co-pay, $20/$25 | $ 2,277.50 | $ 2,464.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **ANTHEM BLUE CROSS PPO PLAN: PBC 80%-L** | Single | Single |
| Medical | $2,000/$4,000 ded, $4000/$8000 out-of-pocket max, $30 co-pay office visit | $ 725.50 | $ 786.50 |
| RX (Prescriptions) | Navitus 10-35 | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,407.00 | $ 1,524.00 |
| Ortho | None | Family | Family |
| Vision | Plan C, Dual Co-pay, $20/$25 | $ 1,966.50 | $ 2,129.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **Kaiser** | Single | Single |
| Medical | $1,500/$3,000 out-of-pocket max, $10 co-pay office visit | $ 824.50 | $ 896.50 |
| RX (Prescriptions) | $10 co-pay for 100 day supply (included in medical) | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,612.00 | $ 1,752.00 |
| Ortho | None | Family | Family |
| Vision | Plan B, Dual co-pay $20/$25 | $ 2,257.50 | $ 2,453.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **ANTHEM BLUE CROSS PPO PLAN: PBC 90%-G** | Single | Single |
| Medical | $500/$1,000 ded, $1,000/$3,000 out-of-pocket max, $20 co-pay office visit | $ 908.50 | $ 982.50 |
| RX (Prescriptions) | Navitus 9-35 | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,766.00 | $ 1,910.00 |
| Ortho | None | Family | Family |
| Vision | Plan C, Dual Co-pay, $20/$25 | $ 2,473.50 | $ 2,676.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **ANTHEM PPO: Minimum Value (HSA $5,000)** | Single | Single |
| Medical | $5,000/$10,000 ded, $6,350/$12,700 out-of-pocket max, Deductible, 30% co-pay office visit | $ 598.50 | $ 646.50 |
| RX (Prescriptions) | Navitus 9-35 | 2- Party | 2- Party |
| Dental | 70/80/90/100 Incentive w/$1500 Max | $ 1,148.00 | $ 1,241.00 |
| Ortho | None | Family | Family |
| Vision | Plan C, Dual Co-pay, $20/$25 | $ 1,596.50 | $ 1,725.50 |
| | **TOTAL MONTHLY PLAN COST** | | |
| | **Anthem PPO: MEC 2-Tier** | | |
| Medical | $9,000/$18,000 ded, $9,000/$18,000 out-of-pocket max, Deductible, 100% co-pay office visit | | |
| RX (Prescriptions) | Navitus Deductible, 100% | | |
| Dental | **MEDICAL ONLY - NO SPOUSAL COVERAGE** | | |
| Ortho | None | | |
| Vision | **MEDICAL ONLY - NO SPOUSAL COVERAGE** | | |
| | **TOTAL MONTHLY PLAN COST** | **EE: $494.00**<br>**EE+CH: $930.00** | **EE: $531.00**<br>**EE+CH: $1,000.00** |

**TO CALCULATE YOUR OUT-OF-POCKET COST:**

1. From column A, find the plan you currently have and enter its total monthly plan cost here:
2. Multiply line one by 3 months: x 3
3. This is the cost of your insurance for the 3 months of 7/1/25 - 9/30/25 =

4. From column B, choose the plan you would like to have for the 9 months between 10/1/25 and 6/30/26 and enter its total monthly plan cost here:
5. Multiply line four by 9 months: x 9
6. This is the cost of your insurance for the 9 months of 10/1/25 - 6/30/26. =

10. Add lines three and six together. This is the annual cost of your insurance between 7/1/25 and 6/30/26.
11. Subtract Your full-time annual cap ( Single $9,299.40, 2-PARTY $17,508.80, Family $ 22,942.20) -
12. This is your total over cap (out-of-pocket expense). =

14. Divide line twelve by 10 months. ÷ 10
15. This is your monthly over cap (out-of-pocket expense) for 12 months of the 2025-26 fiscal year. If you have an over-cap, make sure you are signed up for SISC's no cost Premium Only Plan to save tax money on your premium. =

*** Part-time employees should substitute their prorated monthly CAP for the full-time monthly CAP indicated on line eleven.**

*** If the cost of insurance is less than the cap, the district pays the cost of the insurance instead of the cap.*

**FOR CALCULATION PURPOSES ONLY, ACTUAL COST MAY DIFFER.**