**SOUTH WASHINGTON COUNTY SCHOOLS**
**Teachers .8-1.0 FTE**
Employee Premium Sheet
Jan. 1 - Dec. 31, 2023

| HealthPartners Health Plans<br>Achieve Network | | | | |
|---|---|---|---|---|
| | | **Total Cost Per Month** | **District Cost Per Month** | **Employee Cost Per Pay Period (24 Pay)** |
| **$25 Copay Plan** | Single | $753.75 | $638.16 | $57.80 |
| | Family | $2,020.08 | $1,146.01 | $437.04 |
| **$15 Copay Plan** | Single | $767.88 | $633.06 | $67.41 |
| | Family | $2,057.93 | $1,140.03 | $458.95 |
| **High Deductible Plan*** | Single | $678.31 | $629.42 | $24.45 |
| | Family | $1,817.90 | $1,477.50 | $170.20 |

| HealthPartners Health Plans<br>Open Access Network | | | | |
|---|---|---|---|---|
| | | **Total Cost Per Month** | **District Cost Per Month** | **Employee Cost Per Pay Period (24 Pay)** |
| **$25 Copay Plan** | Single | $801.86 | $638.16 | $81.85 |
| | Family | $2,149.02 | $1,146.01 | $501.51 |
| **$15 Copay Plan** | Single | $816.89 | $633.07 | $91.91 |
| | Family | $2,189.29 | $1,140.03 | $524.63 |
| **High Deductible Plan*** | Single | $721.61 | $669.59 | $26.01 |
| | Family | $1,933.94 | $1,477.50 | $228.22 |

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*If you elect the High Deductible plan, the district will contribute to the employee's HRA/VEBA account an annual amount of $3,000 for the single or family plan, paid per district and contract terms. In a full calendar year, this is distributed as follows:

- 50% of the annual amount on Jan. 15
- 25% of the annual amount on July 15
- 25% of the annual amount on Oct. 15

A VEBA is a tax-free Health Reimbursement Account (HRA) that provides you with a source of funds to offset health care expenses for you, your spouse, and qualified dependents. The VEBA account may be used to pay any qualified pre-retirement medical, dental and/or vision out-of-pocket expenses, plus post-retirement medical, dental, vision insurance premiums, long-term care premiums, Medicare Part B premiums, Medicare deductibles and Medicare Supplemental Plan premiums. You can continue to request reimbursement for eligible expenses until your account is exhausted, even when you are no longer working with the district. Additional information on your VEBA can be found at sowashco.org/benefits.

| Delta Dental Plans<br>Delta Preferred Plan (PPO + Premier Networks) | | | | |
|---|---|---|---|---|
| | | **Total Cost Per Month** | **District Cost Per Month** | **Employee Cost Per Pay Period (24 Pay)** |
| **Dental Plan Rates** | Single | $42.96 | $42.96 | $0.00 |
| | Family | $120.28 | $42.96 | $38.66 |

| EyeMed Vision Plans | | | | |
|---|---|---|---|---|
| | | **Total Cost Per Month** | **District Cost Per Month** | **Employee Cost Per Pay Period (24 Pay)** |
| **Exam + Materials** | Single | $7.27 | $0.00 | $3.64 |
| | Family | $18.55 | $0.00 | $9.28 |
| **Materials Only** | Single | $5.84 | $0.00 | $2.92 |
| | Family | $14.89 | $0.00 | $7.45 |

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| **Ancillary Benefits**<br>**Life and Long-Term Disability**<br>Total Month Premium Charged by Insurer | | |
|---|---|---|
| **Plan Options** | **Life** | **LTD** |
| **District Paid** | | |
| Basic Life $50,000<br>Basic AD and D | $4.30<br>.015/$1,000 | |
| **Employee Paid** | | |
| Supplemental Life Insurance<br>(Per additional $50,000) | $11.00 | |
| Dependent Life Insurance<br>($10,000/spouse, $5,000/child) | $2.20 | |
| Long Term Disability* | | .273 *yearly earnings/$1,000 |

*LTD Max can be found in the benefit plan summaries.

| **The Standard**<br>**Accident Insurance** | |
|---|---|
| **Employee Paid Benefit** | |
| **Coverage Level** | **Total Cost Per Month** |
| Employee Only | $7.35 |
| Employee + Spouse | $11.42 |
| Employee + Children | $14.06 |
| Employee + Spouse + Children | $21.93 |

*Exact amount varies by pay frequency and benefit eligibility start date. Please refer to Benefitfocus for exact amounts.

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## The Standard
## Critical Illness

| Employee Paid Benefit – Employee Monthly Attained Age Premiums | | | | | | |
|---|---|---|---|---|---|---|
| | Employee Age | | | | | |
| **Coverage Amount** | **18-29** | **30-39** | **40-49** | **50-59** | **60-69** | **70+** |
| $10,000 | $2.20 | $3.50 | $7.50 | $16.00 | $29.80 | $52.70 |
| $20,000 | $4.40 | $7.00 | $15.00 | $32.00 | $59.60 | $105.40 |
| $30,000 | $6.60 | $10.50 | $22.50 | $48.00 | $89.40 | $158.10 |
| **Spouse Monthly Attained Age Premiums** | | | | | | |
| | Employee Age | | | | | |
| **Coverage Amount** | **18-29** | **30-39** | **40-49** | **50-59** | **60-69** | **70+** |
| $10,000 | $2.20 | $3.50 | $7.50 | $16.00 | $29.80 | $52.70 |
| $20,000 | $4.40 | $7.00 | $15.00 | $32.00 | $59.60 | $105.40 |
| $30,000 | $6.60 | $10.50 | $22.50 | $48.00 | $89.40 | $158.10 |

*Exact amount varies by pay frequency and benefit eligibility start date. Please refer to Benefitfocus for exact amounts.

## The Standard
## Hospital Indemnity

| Employee Paid Benefit | |
|---|---|
| **Coverage Level** | **Total Cost Per Month** |
| Employee Only | $8.54 |
| Employee + Spouse | $14.46 |
| Employee + Children | $11.88 |
| Employee + Spouse + Children | $21.30 |

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| Allstate<br>Identity Protection Pro+ Cyber | |
|---|---|
| **Employee Paid Benefit** | |
| **Coverage Level** | **Total Cost Per Month** |
| Single | $9.50 |
| Family | $18.50 |

*Exact amount varies by pay frequency and benefit eligibility start date. Please refer to Benefitfocus for exact amounts.