SOUTH WASHINGTON COUNTY SCHOOLS
Executive Cabinet
Employee Premium Sheet
July 1 - Dec. 31, 2022

HealthPartners Health Plans Achieve Network				
		Total Cost Per Month	**District Cost Per Month**	**Employee Cost Per Pay Period (24 Pay)**
$25 Copay Plan	Single	$687.85	$543.90	$71.98
	Family	$1,843.45	$1,434.33	$204.56
$15 Copay Plan	Single	$702.04	$544.76	$78.64
	Family	$1,881.50	$1,436.64	$222.43
High Deductible Plan*	Single	$617.08	$603.37	$6.86
	Family	$1,653.78	$1,645.00	$4.39

HealthPartners Health Plans Open Access Network				
		Total Cost Per Month	**District Cost Per Month**	**Employee Cost Per Pay Period (24 Pay)**
$25 Copay Plan	Single	$731.75	$543.90	$93.93
	Family	$1,961.12	$1,434.33	$263.40
$15 Copay Plan	Single	$746.86	$544.76	$101.05
	Family	$2,001.59	$1,436.64	$282.48
High Deductible Plan*	Single	$656.46	$603.37	$26.55
	Family	$1,759.34	$1,645.00	$57.17

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*If you select the High deductible plan, the district will contribute to the employee's HRA/VEBA account an annual amount of $2,000.04 for the single plan or $3,000 for the 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, 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 **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	$40.21	$1.38
	Family	$120.28	$106.00	$7.14

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 **Life and Long-Term Disability** Total Month Premium Charged by Insurer		
Plan Options	**Life**	**LTD**
District Paid		
Basic Life 3X Salary Basic AD and D	.135/$1,000 .015/$1,000	
Employee Paid		
Supplemental Life Insurance (Additional 2X salary)	.32/$1,000	
Dependent Life Insurance ($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