South Washington County Schools / Employee Premium Sheet

Nutrition Services (at least 30 hours/week)

January 1, 2021– December 31, 2021

HealthPartners Health Plans Achieve Network				
		Total Cost Per Month	District Cost Per Month*	Employee Cost Per Pay Period (19 Pay)
$25 Copay Plan	Single	$635.91	$400.00	$149.00
	Family	$1,704.27	$900.00	$507.96
$15 Copay Plan	Single	$650.15	$400.00	$157.99
	Family	$1,742.41	$900.00	$532.05
High Deductible Plan with VEBA**	Single	$560.36	$468.75	$57.86
	Family	$1,501.78	$1,273.06	$144.45

HealthPartners Health Plans Open Access Network				
		Total Cost Per Month	District Cost Per Month*	Employee Cost Per Pay Period (19 Pay)
$25 Copay Plan	Single	$676.50	$400.00	$174.64
	Family	$1,813.05	$900.00	$576.67
$15 Copay Plan	Single	$691.65	$400.00	$184.20
	Family	$1,853.63	$900.00	$602.29
High Deductible Plan with VEBA**	Single	$596.13	$468.75	$80.45
	Family	$1,597.64	$1,273.06	$205.00

**If you elect the High deductible plan, the district will contribute to the employee's HRA/VEBA account an annual amount of $1,166.52 for the single plan or $1,854.96 for the family plan, paid per district and contract terms. In a full calendar year, this is distributed as follows: 50% of annual amount on January 15, 25% of annual amount on July 15, and 25% of annual amount on October 15.

A VEBA is a tax-fee Health Reimbursement Account (HRA) that provides you with a tax-free 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 here.

Delta Dental Dental Plans Delta Care Plan (Care Network) or Delta Preferred Plan (PPO & Premier Networks)				
		Total Cost Per Month	**District Cost Per Month***	**Employee Cost Per Pay Period (19 Pay)**
Dental Plan Rates	Single	$42.96	$36.23	$4.25
	Family	$120.28	$91.05	$18.46

EyeMed Vision Plans				
		Total Cost Per Month	**District Cost Per Month**	**Employee Cost Per Pay Period (19 Pay)**
Exam + Materials	Single	$7.27	$0.00	$4.59
	Family	$18.55	$0.00	$11.72
Materials only	Single	$5.84	$0.00	$3.69
	Family	$14.89	$0.00	$9.40

ANCILLARY BENEFITS (LIFE AND LONG-TERM DISABILITY) TOTAL MONTHLY PREMIUM CHARGED BY INSURER		
PLAN OPTIONS	**LIFE**	**LTD**
DISTRICT PAID		
BASIC LIFE $50,000 BASIC AD&D	$4.50 .015/$1000	
EMPLOYEE PAID		
SUPPL LIFE (per ADDL $50,000)	$11.00 ($6.95/Pay)	
DEPENDENT LIFE $10,000/spouse, $5,000/child	$2.20 ($1.39/Pay)	
LONG TERM DISABILITY*		.273 * yearly earnings/$1000

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