Health/Vision and Dental Insurance Rates
NON-UNITS

BlueCross BlueShield						Network: Aware	Effective July 1, 2024	
	Health Plans	Copay Plan		ACA Plan		HSA Plan		
	Office Visit Copay	$35		-		-		
	Individual Deductible	$400		$6,400		$3,200		
	Single Monthly Premium	$932.60		$546.71		$693.75		
	Family Monthly Premium	$2,622.82		$1,593.37		$1,985.63		
EMPLOYEE GROUP	DISTRICT CONTRIBUTION PER MONTH	EMPLOYEE'S COST PER MONTH	PAYROLL DEDUCTIONS	EMPLOYEE'S COST PER MONTH	PAYROLL DEDUCTIONS	EMPLOYEE'S COST PER MONTH	PAYROLL DEDUCTIONS	HSA DISTRICT CONTRIBUTION
NON-UNITS- 1 (≥1872 Annual hrs)			x		x			x
SINGLE	$730.12	$202.48	$101.24	$0.00	$0.00	$0.00	$0.00	$36.37
FAMILY	$1,713.86	$908.96	$454.48	$0.00	$0.00	$271.77	$135.89	$0.00
NON-UNITS- Assoicate Admin			^		^			^
SINGLE	$730.12	$202.48	$101.24	$0.00	$0.00	$0.00	$0.00	$36.37
FAMILY	$1,713.86	$908.96	$454.48	$0.00	$0.00	$271.77	$135.89	$0.00
NON-UNITS-NURSES			^		^			^
SINGLE	$730.12	$202.48	$151.86	$0.00	$0.00	$0.00	$0.00	$36.37
FAMILY	$1,406.62	$1,216.20	$912.15	$186.75	$0.00	$579.01	$434.26	$0.00
NON-UNITS- 2 (≥1520 Annual hrs)			^		^			^
SINGLE	$730.12	$202.48	$151.86	$0.00	$0.00	$0.00	$0.00	$36.37
FAMILY	$730.12	$1,892.70	$1,419.53	$863.25	$647.44	$1,255.51	$941.63	$0.00

Delta Dental			
	Single Monthly Premium	$106.30	
	Family Monthly Premium	$106.30	
EMPLOYEE GROUP	DISTRICT CONTRIBUTION PER MONTH	EMPLOYEE'S COST PER MONTH	PAYROLL DEDUCTIONS
NON-UNITS- 1, NON-UNITS- Assoicate Admin			
NON-UNITS-NURSES, NON-UNITS- 2 (≥1520 Annual hrs)			
Single or Family	$106.30	$0.00	$0.00

PAYROLL DEDUCTIONS: x July-June = 24 payroll deductions
PAYROLL DEDUCTIONS: ^ October-May = 16 payroll deductions