

Glendale Elementary School District No. 40

2024 - 2025 Premiums for Medical, Dental & Vision Insurance

- Payroll Deduction Schedule: 8/29/2024 through 6/03/2025 (20 Deductions)
- January 14, 2025 Paycheck has NO deductions for Insurance Premiums
- * Payroll deduction amounts will differ for employees hired after July 1, 2024

MEDICAL & VISION INSURANCE United Healthcare	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	Paycheck Deduction Amount *
TRADITIONAL MEDICAL PLAN					
Employee Only	\$712.47	\$652.47	\$720.00	\$60.00	\$36.00
Employee & Spouse	\$1,471.71	\$1,088.86	\$4,594.20	\$382.85	\$229.71
Employee & Child(ren)	\$1,376.91	\$1,088.86	\$3,456.60	\$288.05	\$172.83
Employee & Family	\$1,803.53	\$1,088.86	\$8,576.04	\$714.67	\$428.81
HIGH DEDUCTIBLE HEALTH PLAN with a HEALTH SAVINGS ACCOUNT (HDHP) (HSA)					
Employee Only	\$652.47	\$652.47	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$1,284.00	\$1,088.86	\$2,341.68	\$195.14	\$117.09
Employee & Child(ren)	\$1,206.26	\$1,088.86	\$1,408.80	\$117.40	\$70.44
Employee & Family	\$1,556.09	\$1,088.86	\$5,606.76	\$467.23	\$280.34
Employees enrolled in the HDHP Plan can earn up to \$1,500 for their HSA Account					
Employer Initial Deposit \$550 - Pro-rated **			Employer Wellness Exam Deposit \$950		
Coverage effective:	07/01 - 09/01	\$550.00	<ul style="list-style-type: none"> • Exam must be done between 01/01/2024 - 12/31/2024 • Availability of funds can take up to 10 days following date of deposit • Deposit schedule: 10/25/2024, 1/24/2025, 2/28/2025 • On the date of the deposit employees must be actively at work and currently enrolled in the HDHP Medical Plan 		
**	10/01 - 12/01	\$450.00			
**	01/01 - 03/01	\$350.00			
**	04/01 - 06/01	\$250.00			
VISION Plan					
Employee Only	\$5.80	\$5.80	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$10.36	\$5.80	\$54.72	\$4.56	\$2.74
Employee & Child(ren)	\$10.85	\$5.80	\$60.60	\$5.05	\$3.03
Employee & Family	\$13.61	\$5.80	\$93.72	\$7.81	\$4.69
DENTAL INSURANCE	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	Paycheck Deduction Amount *
LEVEL I PLAN - DELTA DENTAL					
Employee Only	\$26.11	\$26.11	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$52.22	\$27.92	\$291.60	\$24.30	\$14.59
Employee & Child(ren)	\$54.83	\$27.92	\$322.92	\$26.91	\$16.15
Employee & Family	\$78.32	\$27.92	\$604.80	\$50.40	\$30.25
LEVEL III PLAN - DELTA DENTAL					
Employee Only	\$45.01	\$27.92	\$205.08	\$17.09	\$10.26
Employee & Spouse	\$90.03	\$27.92	\$745.32	\$62.11	\$37.27
Employee & Child(ren)	\$94.53	\$27.92	\$799.32	\$66.61	\$39.97
Employee & Family	\$135.04	\$27.92	\$1,285.44	\$107.12	\$64.28
DHMO PLAN - CIGNA DENTAL					
Employee Only	\$10.30	\$10.30	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$20.37	\$20.37	\$0.00	\$0.00	\$0.00
Employee & Child(ren)	\$22.84	\$22.84	\$0.00	\$0.00	\$0.00
Employee & Family	\$25.06	\$25.06	\$0.00	\$0.00	\$0.00