



HealthPartners Health Plans				
Achieve Network				
		Total Cost Per Month	District Cost Per Month	Employee Cost Per Pay Period (24 pay)
\$25 Copay Plan	Single	\$1,029.35	\$150.00	\$439.68
	Family	\$2,758.67	\$250.00	\$1,254.34
\$15 Copay Plan	Single	\$1,050.33	\$150.00	\$450.17
	Family	\$2,814.92	\$250.00	\$1,282.46
High Deductible Plan \$1,000*	Single	\$917.27	\$873.75	\$21.76
	Family	\$2,458.31	\$1,170.84	\$643.74
High Deductible Plan \$3,000*	Single	\$800.19	\$800.19	\$0.00
	Family	\$2,144.52	\$1,170.84	\$486.84

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	\$1,095.05	\$150.00	\$472.53
	Family	\$2,934.76	\$250.00	\$1,342.38
\$15 Copay Plan	Single	\$1,117.38	\$150.00	\$483.69
	Family	\$2,994.60	\$250.00	\$1,372.30
High Deductible Plan \$1,000	Single	\$975.82	\$873.75	\$51.04
	Family	\$2,615.22	\$1,170.84	\$722.19
High Deductible Plan \$3,000	Single	\$851.26	\$851.26	\$0.00
	Family	\$2,281.41	\$1,170.84	\$555.29



*If you select the High deductible plan, the district will contribute to the employee’s HRA/VEBA account an annual amount of \$1,226.52 for the single and 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.

HealthPartners Dental Plan				
		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	\$60.00	\$30.14

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



Ancillary Benefits Life and Long-Term Disability Total Month Premium Charged by Insurer		
Plan Options	Life	LTD
District Paid		
Basic Life \$10,000 Basic AD and D	\$.86 .015/\$1,000	
Employee Paid		
Supplemental Life Insurance (Per additional \$50,000)	\$11.00 (\$5.50/pay)	
Dependent Life Insurance (\$10,000/spouse, \$5,000/child)	\$2.20 (\$1.10/pay)	
Long Term Disability*		.300 *yearly earnings/\$1,000

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

The Standard 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.



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

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



Allstate 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.