

Glendale Elementary School District No. 40
2025 - 2026 Premiums for Medical, Dental & Vision Insurance

- Payroll Deduction Schedule: 8/26/2025 through 6/02/2026 (20 Deductions)
- January 13, 2026 Paycheck has NO deductions for Insurance Premiums

MEDICAL INSURANCE UNITED HEALTHCARE	Monthly Premium	Employer Contribution Per Month	Employee Cost Per Year	Employee Cost Per Month	PER PAYCHECK AMOUNT
TRADITIONAL MEDICAL PLAN					
Employee Only	\$740.97	\$680.97	\$720.00	\$60.00	\$36.00
Employee & Spouse	\$1,533.74	\$1,150.89	\$4,594.20	\$382.85	\$229.71
Employee & Child(ren)	\$1,438.94	\$1,150.89	\$3,456.60	\$288.05	\$172.83
Employee & Family	\$1,865.56	\$1,150.89	\$8,576.04	\$714.67	\$428.81
HIGH DEDUCTIBLE HEALTH PLAN with a HEALTH SAVINGS ACCOUNT (HDHP) (HSA)					
Employee Only	\$678.57	\$678.57	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$1,337.95	\$1,142.81	\$2,341.68	\$195.14	\$117.09
Employee & Child(ren)	\$1,260.21	\$1,142.81	\$1,408.80	\$117.40	\$70.44
Employee & Family	\$1,610.04	\$1,142.81	\$5,606.76	\$467.23	\$280.34
Employer HSA Deposit \$550 - Pro-rated **		Employer Wellness Exam HSA Deposit \$950			
Coverage effective:	07/01 - 09/01	\$550.00	<ul style="list-style-type: none"> • Exam must be done between 1/01/2025 - 12/31/2025 • Availability of funds can take up to 10 days to post • Deposit schedule: 10/24/2025, 1/22/2026, 2/19/2026 • Must be actively at work and enrolled in the HDHP plan on date of deposit 		
**	10/01 - 12/01	\$450.00			
**	01/01 - 03/01	\$350.00			
**	04/01 - 06/01	\$250.00			
VISION INSURANCE VSP VISION	Monthly Premium	Employer Contribution Per Month	Employee Cost Per Year	Employee Cost Per Month	PER PAYCHECK AMOUNT
CHOICE PLAN					
Employee Only	\$8.92	\$8.92	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$17.83	\$8.92	\$106.92	\$8.91	\$5.35
Employee & Child(ren)	\$19.08	\$8.92	\$121.92	\$10.16	\$6.10
Employee & Family	\$30.50	\$8.92	\$258.96	\$21.58	\$12.95
DENTAL INSURANCE	Monthly Premium	Employer Contribution Per Month	Employee Cost Per Year	Employee Cost Per Month	PER PAYCHECK 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