Cupertino Union School District

DISTRICT/EMPLOYEE MONTHLY CONTRIBUTION CHART FOR EMPLOYEES WORKING 6-8 HRS/DAY

January 1 - December 31, 2026

			12 PAY PERIODS					11 PAY PERIODS	
PLAN TYPE	MONTHLY PREMIUM	MO PREMIUM MINUS EE ONLY RATE	*CUSD'S CONTRIBUTION FOR EMPLOYEE WORKING 6-8 HRS/DAY	EMPLOYEE'S CONTRIBUTION WORKING 6-8 HRS/DAY	MONTHLY PREMIUM	MO PREMIUM MINUS EE ONLY RATE	*CUSD'S CONTRIBUTION FOR EMPLOYEE WORKING 6-8 HRS/DAY	EMPLOYEE'S CONTRIBUTION WORKING 6-8 HRS/DAY
KAISER HMO								
Employee Only	$916.83	$0.00	$916.83	$0.00	$1,000.18	$0.00	$1,000.18	$0.00
2-Party (Employee + 1 family member)	$1,833.66	$916.83	$687.62	$229.21	$2,000.36	$1,000.17	$750.13	$250.04
Family (Employee + 2 or more family members)	$2,594.63	$1,677.80	$1,258.35	$419.45	$2,830.51	$1,830.33	$1,372.75	$457.58
KAISER DEDUCTIBLE HMO								
Employee Only	$803.48	$0.00	$803.48	$0.00	$876.52	$0.00	$876.52	$0.00
2-Party (Employee + 1 family member)	$1,606.96	$803.48	$602.61	$200.87	$1,753.05	$876.52	$657.39	$219.13
Family (Employee + 2 or more family members)	$2,273.85	$1,470.37	$1,102.78	$367.59	$2,480.56	$1,604.04	$1,203.03	$401.01
KAISER HEALTH SAVINGS ACCOUNT 1800								
Employee Only	$753.83	$0.00	$753.83	$0.00	$822.36	$0.00	$822.36	$0.00
2-Party (Employee + 1 family member)	$1,507.66	$753.83	$565.37	$188.46	$1,644.72	$822.36	$616.77	$205.59
Family (Employee + 2 or more family members)	$2,133.34	$1,379.51	$1,034.63	$344.88	$2,327.28	$1,504.92	$1,128.69	$376.23
UNITEDHEALTHCARE (UHC) SIGNATURE VALUE FULL NETWORK (+ Sutter Health)								
Employee Only	$1,078.76	$0.00	$1,078.76	$0.00	$1,176.83	$0.00	$1,176.83	$0.00
2-Party (Employee + 1 family member)	$2,112.40	$1,033.64	$775.23	$258.41	$2,304.44	$1,127.61	$845.71	$281.90
Family (Employee + 2 or more family members)	$3,004.96	$1,926.20	$1,444.65	$481.55	$3,278.14	$2,101.31	$1,575.98	$525.33
UNITEDHEALTHCARE (UHC) SIGNATURE VALUE ALLIANCE (Sutter Health Network only)								
Employee Only	$1,054.94	$0.00	$1,054.94	$0.00	$1,150.84	$0.00	$1,150.84	$0.00
2-Party (Employee + 1 family member)	$2,065.76	$1,010.82	$758.11	$252.71	$2,253.56	$1,102.71	$827.03	$275.68
Family (Employee + 2 or more family members)	$2,938.61	$1,883.67	$1,412.75	$470.92	$3,205.76	$2,054.91	$1,541.18	$513.73
UHC PPO (no new enrollments; for grandfathered members only)								
Employee Only	$1,909.01	$0.00	$1,909.01	$0.00	$2,082.56	$0.00	$2,082.56	$0.00
2-Party (Employee + 1 family member)	$3,997.87	$2,088.86	$1,566.65	$522.21	$4,361.31	$2,278.76	$1,709.07	$599.69
Family (Employee + 2 or more family members)	$5,706.69	$3,797.68	$2,848.26	$949.42	$6,225.48	$4,142.92	$3,107.19	$1,035.73

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PLAN TYPE	MONTHLY PREMIUM	MO PREMIUM MINUS EE ONLY RATE	*CUSD'S CONTRIBUTION FOR EMPLOYEE WORKING 6-8 HRS/DAY	EMPLOYEE'S CONTRIBUTION WHO WORKS 6-8 HRS/DAY	MONTHLY PREMIUM	MO PREMIUM MINUS EE ONLY RATE	*CUSD'S CONTRIBUTION FOR EMPLOYEE WORKING 6-8 HRS/DAY	EMPLOYEE'S CONTRIBUTION WHO WORKS 6-8 HRS/DAY
UHC HEALTH SAVINGS ACCOUNT (no new enrollments; for grandfathered members only)								
Employee Only	$1,403.58	$0.00	$1,403.58	$0.00	$1,531.18	$0.00	$1,531.18	$0.00
2-Party (Employee + 1 family member)	$2,939.40	$1,535.82	$1,151.87	$383.95	$3,206.62	$1,675.44	$1,256.58	$418.86
Family (Employee + 2 or more family members)	$4,195.80	$2,792.22	$2,094.17	$698.05	$4,577.24	$3,046.06	$2,284.54	$761.52
DELTA PPO PREMIER DENTAL								
Employee Only	$76.14	$0.00	$76.14	$0.00	$83.06	$0.00	$83.06	$0.00
2-Party (Employee + 1 family member)	$148.48	$72.34	$54.26	$18.08	$161.98	$78.91	$59.19	$19.72
Family (Employee + 2 or more family members)	$233.37	$157.23	$117.92	$39.31	$254.59	$171.52	$128.64	$42.88
DELTA DENTAL LOW COST PLAN								
Employee Only	$40.52	$0.00	$40.52	$0.00	$44.20	$0.00	$44.20	$0.00
2-Party (Employee + 1 family member)	$79.00	$38.48	$28.86	$9.62	$86.18	$41.98	$31.48	$10.49
Family (Employee + 2 or more family members)	$123.66	$83.14	$62.36	$20.78	$134.90	$90.70	$68.03	$22.67
DELTACARE HMO (composite rate))								
Employee Only	$54.49	$0.00	$54.49	$0.00	$59.44	$0.00	$59.44	$0.00
Family (Employee + 1 or more family members)	$54.49	$0.00	$40.87	$13.62	$59.44	$0.00	$44.58	$14.86
VISION SERVICE PLAN								
Employee Only	$7.44	$0.00	$7.44	$0.00	$8.12	$0.00	$8.12	$0.00
2-Party (Employee + 1 family member)	$14.90	$7.46	$5.60	$1.86	$16.25	$8.14	$6.11	$2.03
Family (Employee + 2 or more family members)	$23.99	$16.55	$12.41	$4.14	$26.17	$18.05	$13.54	$4.51
GROUP LIFE INSURANCE (mandatory if enrolling in medical)								
Employee Only	$14.02	$0.00	$14.02	$0.00	$15.29	$0.00	$15.29	$0.00
Family (Employee + 1 or more family members)	$14.62	$0.60	$0.45	$0.15	$15.95	$0.65	$0.49	$0.16

NOTES:

District pays 100% of the employee only monthly premium for an employee working 6-8 hours per day

Employee deductions are taken pre-tax .

10-10-25 HR/an