

**CAESAR RODNEY SCHOOL DISTRICT
FY 26 HEALTH INSURANCE RATES
EFFECTIVE FEBRUARY 1, 2025
FULL-TIME AND PART-TIME EMPLOYEES**

STATE OF DELAWARE GROUP HEALTH INSURANCE PLAN	Cost for Full-Time Employees (before State Share and Flex Credit) & Cost paid by Part-Time Employees		Cost paid by State (State Share)		Employee Premium w/o Flex Credit		Flex Credit (Paid by CRSD)		Cost paid by Full-Time Employees (after State Share and Flex Credit)	
	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay
HIGHMARK - COMP PPO										
EMPLOYEE ONLY	\$1,248.56	\$624.28	\$1,083.12	\$541.56	\$165.44	\$82.72	\$135.00	\$67.50	\$30.44	\$15.22
EMPLOYEE & SPOUSE	\$2,590.92	\$1,295.46	\$2,247.62	\$1,123.81	\$343.30	\$171.65	\$135.00	\$67.50	\$208.30	\$104.15
EMPLOYEE & CHILD(REN)	\$1,924.26	\$962.13	\$1,669.30	\$834.65	\$254.96	\$127.48	\$135.00	\$67.50	\$119.96	\$59.98
FAMILY	\$3,239.00	\$1,619.50	\$2,809.84	\$1,404.92	\$429.16	\$214.58	\$135.00	\$67.50	\$294.16	\$147.08
HIGHMARK - FIRST STATE BASIC										
EMPLOYEE ONLY	\$1,093.66	\$546.83	\$1,049.92	\$524.96	\$43.74	\$21.87	\$43.74	\$21.87	\$0.00	\$0.00
EMPLOYEE & SPOUSE	\$2,262.74	\$1,131.37	\$2,172.24	\$1,086.12	\$90.50	\$45.25	\$90.50	\$45.25	\$0.00	\$0.00
EMPLOYEE & CHILD(REN)	\$1,662.46	\$831.23	\$1,595.96	\$797.98	\$66.50	\$33.25	\$66.50	\$33.25	\$0.00	\$0.00
FAMILY	\$2,828.52	\$1,414.26	\$2,715.38	\$1,357.69	\$113.14	\$56.57	\$113.14	\$56.57	\$0.00	\$0.00
AETNA - HMO PLAN										
EMPLOYEE ONLY	\$1,141.76	\$570.88	\$1,067.54	\$533.77	\$74.22	\$37.11	\$74.22	\$37.11	\$0.00	\$0.00
EMPLOYEE & SPOUSE	\$2,407.30	\$1,203.65	\$2,250.82	\$1,125.41	\$156.48	\$78.24	\$135.00	\$67.50	\$21.48	\$10.74
EMPLOYEE & CHILD(REN)	\$1,746.60	\$873.30	\$1,633.08	\$816.54	\$113.52	\$56.76	\$113.52	\$56.76	\$0.00	\$0.00
FAMILY	\$3,003.76	\$1,501.88	\$2,808.52	\$1,404.26	\$195.24	\$97.62	\$135.00	\$67.50	\$60.24	\$30.12
AETNA - CDH GOLD										
EMPLOYEE ONLY	\$1,131.92	\$565.96	\$1,075.32	\$537.66	\$56.60	\$28.30	\$56.60	\$28.30	\$0.00	\$0.00
EMPLOYEE & SPOUSE	\$2,346.96	\$1,173.48	\$2,229.62	\$1,114.81	\$117.34	\$58.67	\$117.34	\$58.67	\$0.00	\$0.00
EMPLOYEE & CHILD(REN)	\$1,729.38	\$864.69	\$1,642.92	\$821.46	\$86.46	\$43.23	\$86.46	\$43.23	\$0.00	\$0.00
FAMILY	\$2,981.60	\$1,490.80	\$2,832.52	\$1,416.26	\$149.08	\$74.54	\$135.00	\$67.50	\$14.08	\$7.04
CAESAR RODNEY DENTAL & VISION PLANS					Full Cost		Paid by District		Paid by Employee	
CR Pays the full cost of the Dental premium for Employee, Employee & Spouse and Employee & Children, CR will pay up to \$115.00 for Family, balance will be charged to the employee Part-Time employees pay the full cost. CR Pays the Full cost of the Vision premium for Full-Time Employees. Vision coverage not available to employees that work less than 30 hours per week.										
					Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay
DELTA DENTAL-DENTAL COVERAGE										
EMPLOYEE ONLY					\$68.67	\$34.34	\$68.67	\$34.34	\$0.00	\$0.00
EMPLOYEE & SPOUSE					\$92.59	\$46.30	\$92.59	\$46.30	\$0.00	\$0.00
EMPLOYEE & CHILD(REN)					\$103.13	\$51.57	\$103.13	\$51.57	\$0.00	\$0.00
FAMILY					\$127.05	\$63.53	\$115.00	\$57.50	\$12.05	\$6.03
AMERITAS VSP -VISION										
EMPLOYEE ONLY					\$6.96	\$3.48	\$6.96	\$3.48	\$0.00	\$0.00
EMPLOYEE & SPOUSE					\$14.32	\$7.16	\$14.32	\$7.16	\$0.00	\$0.00
EMPLOYEE & CHILD(REN)					\$12.52	\$6.26	\$12.52	\$6.26	\$0.00	\$0.00
FAMILY					\$19.88	\$9.94	\$19.88	\$9.94	\$0.00	\$0.00