

Glendale Elementary School District No. 40
2026 - 2027 Premiums for Medical, Dental & Vision Insurance

- Payroll Deduction Schedule: 8/25/2026 through 6/01/2027 (20 deductions)
- January 12, 2027 Paycheck has NO insurance premium deductions

MEDICAL INSURANCE	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	DEDUCTION PER PAYCHECK
UNITED HEALTHCARE TRADITIONAL MEDICAL PLAN					
Employee Only	\$780.33	\$720.33	\$720.00	\$60.00	\$36.00
Employee & Spouse	\$1,592.85	\$1,210.00	\$4,594.20	\$382.85	\$229.71
Employee & Child(ren)	\$1,498.05	\$1,210.00	\$3,456.60	\$288.05	\$172.83
Employee & Family	\$1,924.67	\$1,210.00	\$8,576.04	\$714.67	\$428.81
UNITED HEALTHCARE HIGH DEDUCTIBLE HEALTH PLAN w/ Health Savings Account					
Employee Only	\$717.33	\$717.33	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$1,398.84	\$1,203.70	\$2,341.68	\$195.14	\$117.09
Employee & Child(ren)	\$1,321.10	\$1,203.70	\$1,408.80	\$117.40	\$70.44
Employee & Family	\$1,670.93	\$1,203.70	\$5,606.76	\$467.23	\$280.34
Employer HSA Annual Deposit		Employer HSA Wellness Exam Deposit \$950			
Insurance effective: 07/01 - 09/01	\$550.00	• Exam must be done between 1/01/2026 - 12/31/2026 • Availability of funds can take up to 10 days to post • Deposit schedule: 10/23/2026, 1/22/2027, 2/19/2027 • On deposit dates you must be actively at work and enrolled in the HDHP plan			
Insurance effective: 10/01 - 12/01	\$450.00				
Insurance effective: 01/01 - 03/01	\$350.00				
Insurance effective: 04/01 - 06/01	\$250.00				
VISION INSURANCE	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	DEDUCTION PER PAYCHECK
VSP VISION 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 Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	DEDUCTION PER PAYCHECK
DELTA DENTAL LEVEL I PLAN					
Employee Only	\$23.32	\$23.32	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$52.22	\$27.92	\$291.60	\$24.30	\$14.59
Employee & Child(ren)	\$50.82	\$27.92	\$274.80	\$22.90	\$13.74
Employee & Family	\$78.32	\$27.92	\$604.80	\$50.40	\$30.25
DELTA DENTAL LEVEL III PLAN					
Employee Only	\$43.38	\$27.92	\$185.52	\$15.46	\$9.28
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
CIGNA DENTAL DHMO PLAN - Employer pays the premium					
Employee Only	\$10.82	\$10.82	\$0.00	\$0.00	\$0.00
Employee & Spouse	\$21.39	\$21.39	\$0.00	\$0.00	\$0.00
Employee & Child(ren)	\$23.99	\$23.99	\$0.00	\$0.00	\$0.00
Employee & Family	\$26.32	\$26.32	\$0.00	\$0.00	\$0.00