SOUTH WASHINGTON COUNTY SCHOOLS
Independents Miscellaneous
Employee Premium Sheet
Jan. 1 - Dec. 31, 2027

HealthPartners Health Plans Achieve Network					
		Total Cost Per Month	**District Cost Per Month**	**Employee Cost Per Pay Period (24 pay)**	**Employee Cost Per Pay Period (18 pay)**
$25 Copay Plan	Single	$1,278.37	$899.99	$189.19	$252.25
	Family	$3,426.06	$2,373.38	$526.34	$701.79
$15 Copay Plan	Single	$1,304.24	$901.42	$201.41	$268.55
	Family	$3,495.41	$2,377.20	$559.11	$745.47
High Deductible Plan $1,000*	Single	$1,145.82	$1,020.35	$62.74	$83.65
	Family	$3,070.82	$2,721.41	$174.71	$232.94
High Deductible Plan $3,000*	Single	$1,008.25	$976.88	$15.69	$20.91
	Family	$2,702.14	$2,618.03	$42.06	$56.07

HealthPartners Health Plans Open Access Network					
		Total Cost Per Month	**District Cost Per Month**	**Employee Cost Per Pay Period (24 pay)**	**Employee Cost Per Pay Period (18 pay)**
$25 Copay Plan	Single	$1,359.96	$899.99	$229.99	$306.65
	Family	$3,644.74	$2,373.38	$635.68	$847.57
$15 Copay Plan	Single	$1,387.49	$901.42	$243.04	$324.05
	Family	$3,718.52	$2,377.20	$670.66	$894.21
High Deductible Plan $1,000*	Single	$1,218.95	$1,085.50	$66.73	$88.97
	Family	$3,266.83	$2,721.99	$272.42	$363.23
High Deductible Plan $3,000*	Single	$1,072.61	$1,039.21	$16.70	$22.27
	Family	$2,874.62	$2,721.99	$76.32	$101.75

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*If you select the High deductible plan, the district will contribute to the employee's HRA/VEBA account an annual amount of $2,000.04 for the single plan or $3,999.96 for the 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)	Employee Cost Per Pay Period (18 Pay)
Dental Plan Rates	Single	$42.96	$42.96	$0.00	$0.00
	Family	$120.28	$120.28	$0.00	$0.00

EyeMed Vision Plans

		Total Cost Per Month	District Cost Per Month	Employee Cost Per Pay Period (24 Pay)	Employee Cost Per Pay Period (18 Pay)
Exam + Materials	Single	$7.27	$0.00	$3.64	$4.85
	Family	$18.55	$0.00	$9.28	$12.37
Materials Only	Single	$5.84	$0.00	$2.92	$3.89
	Family	$14.89	$0.00	$7.45	$9.93

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Ancillary Benefits **Life and Long-Term Disability** Total Month Premium Charged by Insurer		
Plan Options	**Life**	**LTD**
District Paid		
Basic Life $50,000 Basic AD&D	$4.30 .015/$1,000	
Employee Paid		
Supplemental Life Insurance (Per additional $50,000)	$11.00	
Dependent Life Insurance ($10,000/spouse, $5,000/child)	$2.20	
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

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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

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

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Allstate **Identity Protection Pro+ Cyber**	
Employee Paid Benefit	
Coverage Level	**Total Cost Per Month**
Single	$9.50
Family	$18.50

PLEASE NOTE: Premium amounts may differ based on pay frequency and benefit eligibility start date. Please refer to Benefitfocus for exact amounts.