CUSD HEALTH & WELFARE MONTHLY PREMIUM RATES
Effective January 1 - December 31, 2027

PLAN TYPE	UNPAID LEAVE OF ABSENCE	COBRA w/ 2% admin fee
Kaiser HMO		
Single	$ 951.79	$ 970.83
2-Party (Subscriber + 1 dependent)	$ 1,903.58	$ 1,941.65
Family (Subscriber + 2 or more dependents)	$ 2,693.57	$ 2,747.44
Kaiser Deductible HMO		
Single	$ 827.91	$ 844.47
2-Party (Subscriber + 1 dependent)	$ 1,655.82	$ 1,688.94
Family (Subscriber + 2 or more dependents)	$ 2,342.99	$ 2,389.85
Kaiser Health Savings Account 1800		
Single	$ 782.59	$ 798.24
2-Party (Subscriber + 1 dependent)	$ 1,565.18	$ 1596.48
Family (Subscriber + 2 or more dependents)	$ 2,214.73	$ 2,259.02
UnitedHealthcare $30 Signature Value Full Network (*including Sutter Health*)		
Single	$ 1,165.05	$ 1,188.35
2-Party (Subscriber + 1 dependent)	$ 2,281.36	$ 2,326.99
Family (Subscriber + 2 or more dependents)	$ 3,245.32	$ 3,310.23
UnitedHealthcare $30 Signature Value Alliance (*Sutter Health Network Only*)		
Single	$ 1,139.32	$ 1,188.35
2-Party (Subscriber + 1 dependent)	$ 2,230.99	$ 2,275.61
Family (Subscriber + 2 or more dependents)	$ 3,173.66	$ 3,237.13
UnitedHealthcare PPO Select Plus (*closed to new enrollment*)		
Single	$ 2,354.69	$ 2,401.78
2-Party (Subscriber + 1 dependent)	$ 4,931.22	$ 5,029.84
Family (Subscriber + 2 or more dependents)	$ 7,038.98	$ 7,179.76
UnitedHealthcare Health Savings Account (*closed to new enrollment*)		
Single	$ 1,725.50	$ 1,760.01
2-Party (Subscriber + 1 dependent)	$ 3,613.57	$ 3,685.84
Family (Subscriber + 2 or more dependents)	$ 5,158.13	$ 5,261.29

CUSD HEALTH & WELFARE MONTHLY PREMIUM RATES
Effective January 1 - December 31, 2027

PLAN TYPE	UNPAID LEAVE OF ABSENCE	COBRA w/ 2% adm fee
DeltaCare HMO Dental *(one rate only)*	$ 54.49	$ 55.58
Delta Dental Low Cost Plan		
Single	$ 40.52	$ 41.33
2-Party (Subscriber + 1 dependent)	$ 79.00	$ 80.58
Family (Subscriber + 2 or more dependents)	$ 123.66	$ 126.13
Delta PPO Premier Dental		
Single	$ 76.14	$ 77.66
2-Party (Subscriber + 1 dependent)	$ 148.48	$ 151.45
Family (Subscriber + 2 or more dependents)	$ 233.37	$ 238.04
Vision Service Plan		
Single	$ 8.56	$ 8.73
2-Party (Subscriber + 1 dependent)	$ 17.14	$ 17.48
Family (Subscriber + 2 or more dependents)	$ 27.59	$ 28.14
Group Term Life Insurance (*includes Accidental Death & Dismemberment for employee only)*		
Mandatory enrollment if employee is enrolling in a medical plan		
Single	$ 14.02	na
Family (Employee with Dependents)	$ 14.62	na

HR/kp
9/30/26