Glendale Elementary School District No. 40

2024 - 2025 Premiums for Medical, Dental & Vision Insurance

- Payroll Deduction Schedule: 8/27/2024 through 6/03/2025 (20 Deductions)
- January 14, 2025 Paycheck has NO deducitons for Insurance Premiums

***** Payroll deduction amounts will differ for employees hired after July 1, 2024

MEDICAL & VISION INSURANCE United Healthcare	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	Paycheck Deduction Amount *
TRADITIONAL MEDICAL PLAN					
Employee Only	$712.47	$652.47	$720.00	$60.00	**$36.00**
Employee & Spouse	$1,471.71	$1,088.86	$4,594.20	$382.85	**$229.71**
Employee & Child(ren)	$1,376.91	$1,088.86	$3,456.60	$288.05	**$172.83**
Employee & Family	$1,803.53	$1,088.86	$8,576.04	$714.67	**$428.81**
HIGH DEDUCTIBLE HEALTH PLAN with a HEALTH SAVINGS ACCOUNT (HDHP) (HSA)					
Employee Only	$652.47	$652.47	$0.00	$0.00	**$0.00**
Employee & Spouse	$1,284.00	$1,088.86	$2,341.68	$195.14	**$117.09**
Employee & Child(ren)	$1,206.26	$1,088.86	$1,408.80	$117.40	**$70.44**
Employee & Family	$1,556.09	$1,088.86	$5,606.76	$467.23	**$280.34**

Employees enrolled in the HDHP Plan can earn up to $1,500 for their HSA Account

Employer Initial Deposit $550 - Pro-rated **			Employer Wellness Exam Deposit $950
Coverage effective:	07/01 - 09/01	$550.00	• Exam must be done between 01/01/2024 - 12/31/2024 • Availability of funds can take up to 10 days following date of deposit • Deposit schedule: 10/25/2024, 1/24/2025, 2/28/2025 • On the date of the deposit employees must be actively at work and currently enrolled in the HDHP Medical Plan
**	10/01 - 12/01	$450.00	
**	01/01 - 03/01	$350.00	
**	04/01 - 06/01	$250.00	

VISION Plan					
Employee Only	$5.80	$5.80	$0.00	$0.00	**$0.00**
Employee & Spouse	$10.36	$5.80	$54.72	$4.56	**$2.74**
Employee & Child(ren)	$10.85	$5.80	$60.60	$5.05	**$3.03**
Employee & Family	$13.61	$5.80	$93.72	$7.81	**$4.69**

DENTAL INSURANCE	Monthly Premium	Employer Monthly Contribution	Employee Annual Cost	Employee Monthly Cost	Paycheck Deduction Amount *
LEVEL I PLAN - DELTA DENTAL					
Employee Only	$26.11	$26.11	$0.00	$0.00	**$0.00**
Employee & Spouse	$52.22	$27.92	$291.60	$24.30	**$14.59**
Employee & Child(ren)	$54.83	$27.92	$322.92	$26.91	**$16.15**
Employee & Family	$78.32	$27.92	$604.80	$50.40	**$30.25**
LEVEL III PLAN - DELTA DENTAL					
Employee Only	$45.01	$27.92	$205.08	$17.09	**$10.26**
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**
DHMO PLAN - CIGNA DENTAL					
Employee Only	$10.30	$10.30	$0.00	$0.00	**$0.00**
Employee & Spouse	$20.37	$20.37	$0.00	$0.00	**$0.00**
Employee & Child(ren)	$22.84	$22.84	$0.00	$0.00	**$0.00**
Employee & Family	$25.06	$25.06	$0.00	$0.00	**$0.00**