

FY2022/23 MONTHLY PREMIUMS

RATES EFFECTIVE 07/01/2022 THROUGH 06/30/2023

Premiums are calculated per month. The amount under the “employee” column is what the employee pays per month. The 9 month rates are calculated for food service employees since this group pays for 12 months of coverage in 9 months. The amount under the “District” column is the amount District 11 pays for your benefits per month.

RATES FOR 12-MONTH EMPLOYEES

EPO MEDICAL Group # CB560	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 135.67	\$ 407.00	\$ 542.67
EMPLOYEE + SPOUSE	\$ 360.21	\$ 840.48	\$ 1,200.69
EMPLOYEE + CHILD(REN)	\$ 295.96	\$ 690.58	\$ 986.54
EMPLOYEE + FAMILY	\$ 471.77	\$ 1,100.79	\$ 1,572.56

DELTA DENTAL PPO + PREMIER GROUP # 1563	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 12.67	\$ 38.01	\$ 50.68
EMPLOYEE + FAMILY	\$ 66.67	\$ 38.01	\$ 104.68

DELTA DENTAL PPO (IN-NETWORK ONLY) GROUP # 9098	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 8.07	\$ 24.22	\$ 32.29
EMPLOYEE + FAMILY	\$ 50.87	\$ 24.22	\$ 75.09

EYEMED VISION ACCESS PLAN #9764168	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 1.37	\$ 4.18	\$ 5.55
EMPLOYEE + FAMILY	\$ 11.15	\$ 4.18	\$ 15.33

RATES FOR 9-MONTH EMPLOYEES- FOOD SERVICE ONLY

EPO MEDICAL Group # CB560	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 180.89	\$ 542.67	\$ 723.56
EMPLOYEE + SPOUSE	\$ 480.28	\$ 1,120.64	\$ 1,600.92
EMPLOYEE + CHILD(REN)	\$ 394.62	\$ 920.77	\$ 1,315.39
EMPLOYEE + FAMILY	\$ 629.02	\$ 1,467.72	\$ 2,096.75

DELTA DENTAL PPO + PREMIER GROUP # 1563	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 16.89	\$ 50.68	\$ 67.57
EMPLOYEE + FAMILY	\$ 88.89	\$ 50.68	\$ 139.57

DELTA DENTAL PPO (IN-NETWORK ONLY) GROUP # 9098	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 10.76	\$ 32.29	\$ 43.05
EMPLOYEE + FAMILY	\$ 67.83	\$ 32.29	\$ 100.12

EYEMED VISION ACCESS PLAN #9764168	EMPLOYEE COST-Monthly	DISTRICT COST- Monthly	TOTAL MONTHLY PREMIUM
EMPLOYEE ONLY	\$ 1.85	\$ 5.55	\$ 7.40
EMPLOYEE + FAMILY	\$ 14.89	\$ 5.55	\$ 20.44

PRORATION OF PREMIUMS

TEACHERS ONLY

RATES EFFECTIVE 07/01/2022 THROUGH 06/30/2023

Insurance premiums will be prorated for all **teachers** working less than 7 hours a day. If your hours fall into one of the categories listed below, the insurance rates will be pro-rated. See example below.

A teacher working 3 ½ hours a day will be .41% of full-time. The District shares 75% of the health insurance premium for the full-time employee (FTE). Therefore, the district will share .50% of the 75% for a 3 ½ hour teacher. Less than 3 ½ hours a day will not be eligible for benefits.

EMPLOYEE COST

.41 - .50 FTE 50%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST Monthly
EMPLOYEE ONLY	\$ 339.17	\$31.68	\$20.18	\$3.46
EMPLOYEE + SPOUSE	\$ 780.45	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 641.25	-----	-----	-----
EMPLOYEE + FAMILY	\$ 1,022.16	\$85.68	\$62.98	\$13.24
.51 - .60 FTE 60%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST- Monthly
EMPLOYEE ONLY	\$ 298.47	\$27.87	\$17.76	\$3.04
EMPLOYEE + SPOUSE	\$ 696.40	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 572.19	-----	-----	-----
EMPLOYEE + FAMILY	\$ 912.08	\$81.87	\$60.56	\$12.82
.61 - .70 FTE 70%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST- Monthly
EMPLOYEE ONLY	\$ 257.77	\$24.07	\$15.34	\$2.62
EMPLOYEE + SPOUSE	\$ 612.35	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 503.14	-----	-----	-----
EMPLOYEE + FAMILY	\$ 802.01	\$78.07	\$58.14	\$12.40
.71 - .80 FTE 80%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST- Monthly
EMPLOYEE ONLY	\$ 217.07	\$20.27	\$12.91	\$2.21
EMPLOYEE + SPOUSE	\$ 528.30	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 434.08	-----	-----	-----
EMPLOYEE + FAMILY	\$ 691.93	\$74.27	\$55.72	\$11.99
.81 - .90 FTE 90%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST- Monthly
EMPLOYEE ONLY	\$ 176.37	\$16.47	\$10.49	\$2.00
EMPLOYEE + SPOUSE	\$ 444.26	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 365.02	-----	-----	-----
EMPLOYEE + FAMILY	\$ 581.85	\$70.47	\$53.29	\$11.78
.91 - 1.0 FTE 100%	MEDICAL EMPLOYEE COST- Monthly	DENTAL PPO+ PREMIER EMPLOYEE COST- Monthly	DENTAL PPO IN-NETWORK ONLY EMPLOYEE COST- Monthly	EYEMED VISION EMPLOYEE COST- Monthly
EMPLOYEE ONLY	\$ 135.67	\$12.67	\$8.07	\$1.37
EMPLOYEE + SPOUSE	\$ 360.21	-----	-----	-----
EMPLOYEE + CHILD(REN)	\$ 295.96	-----	-----	-----
EMPLOYEE + FAMILY	\$ 471.77	\$66.67	\$50.87	\$11.15