2027 INSURANCE PREMIUM RATE SCHEDULE

Administration; Community Services Coordinators; Confidential; Custodians; Head Custodians; Child Nutrition; Maintenance/Grnds/Electrical Coordinators; Nurses; COTA/Speech Language; Office Employees; Other Staff Principals; Superintendent; Technology; Educational Assistants *

HEALTH INSURANCE - BCBS of MN - Rates Effective January 1, 2027 through December 31, 2027

Option 1 HEALTH INSURANCE: $1500/$3000 CMM Plan

COST PER MONTH:		**A: 6-8 hrs/dy 30-40 hrs/wk**	**B: 5-<6 hrs/dy 25-<30 hrs/wk**	**C: 4-<5 hrs/dy 20-<25 hrs/wk**
SINGLE	**Employee Share:**	**$285.06**	**$599.30**	**$677.87**
	Board Contribution:	$785.61	$471.37	$392.81
	Total Premium:	$1,070.67	$1,070.67	$1,070.67
Single Cost Per Check with Year Round Deductions		$142.53	$299.65	$338.93
Single Cost Per Check with 16 Pay Periods Deductions		$213.80	$449.48	$508.40
FAMILY	**Employee Share:**	**$868.16**	**$1,823.77**	**$2,062.67**
	Board Contribution:	$2,389.02	$1,433.41	$1,194.51
	Total Premium:	$3,257.18	$3,257.18	$3,257.18
Family Cost Per Check with Year Round Deductions		$434.08	$911.88	$1,031.34
Family Cost Per Check with 16 Pay Periods Deductions		$651.12	$1,367.83	$1,547.00

Option 2 **HEALTH INSURANCE: Health Reimbursement Account**

COST PER MONTH:		**A: 6-8 hrs/dy 30-40 hrs/wk**	**B: 5-<6 hrs/dy 25-<30 hrs/wk**	**C: 4-<5 hrs/dy 20-<25 hrs/wk**
	Total Premium:	$1,062.62	$1,062.62	$1,062.62
	Board Contribution:	$785.61	$471.37	$392.81
	HRA Funding	$83.33	$83.33	$83.33
***	Net District Contribution	$702.28	$388.04	$309.48
SINGLE	**Employee Share:**	**$360.34**	**$674.58**	**$753.15**
Single Cost Per Check with Year Round Deductions		$180.17	$337.29	$376.57
Single Cost Per Check with 16 Pay Periods Deductions		$270.26	$505.94	$564.86
	Total Premium:	$3,230.73	$3,230.73	$3,230.73
	Board Contribution:	$2,389.02	$1,433.41	$1,194.51
	HRA Funding	$166.67	$166.67	$166.67
****	Net District Contribution	$2,222.35	$1,266.74	$1,027.84
FAMILY	**Employee Share:**	**$1,008.38**	**$1,963.99**	**$2,202.89**
Family Cost Per Check with Year Round Deductions		$504.19	$981.99	$1,101.45
Family Cost Per Check with 16 Pay Periods Deductions		$756.29	$1,472.99	$1,652.17

District Funds 50% of the HRA Deductible ($1,000/single or $2,000/family)

***Single= $1,000.00/12 = $83.33/month contribution towards HRA. Regular monthly contribution by the District toward monthly premium is $785.61. The $83.33/mo. that is contributed towards the HRA is subtracted from the regular monthly contribution paid by the District towards premium. $785.61 - $83.33 = $702.28 to be paid by the District towards the monthly premium.

****Family = $2,000.00/12 = $166.67/month contribution towards HRA. Regular monthly contribution by the District toward monthly premium is $2,389.02. The $166.67/mo. that is contributed towards the HRA is subtracted from the regular monthly contribution paid by the District towards premium. $2,389.02 - $166.67 = $2,222.35 to be paid by the District towards the monthly premium.

Administration; Community Services Coordinators; Confidential; Custodians; Head Custodians; Child Nutrition; Maintenance/Grnds/Electrical Coordinators; Nurses; COTA/Speech Language; Office Employees; Other Staff; Principals; Superintendent; Technology; Educational Assistants *

DENTAL INSURANCE: Delta Dental - Rates Effective January 1, 2027 through December 31, 2027

COST PER MONTH:

		A: 6-8 hrs/dy 30-40 hrs/wk	B: 5-<6 hrs/dy 25-<30 hrs/wk	C: 4-<5 hrs/dy 20-<25 hrs/wk
SINGLE	**Employee Share:**	**$13.77**	**$25.05**	**$27.87**
	Board Contribution:	$28.20	$16.92	$14.10
	Total Premium:	$41.97	$41.97	$41.97
Single Cost Per Check with Year Round Deductions		$6.89	$12.53	$13.94
Single Cost Per Check with 16 Pay Perids Deductions		$10.33	$18.79	$20.90

FAMILY	**Employee Share:**	**$59.37**	**$85.11**	**$91.54**
	Board Contribution:	$64.34	$38.60	$32.17
	Total Premium:	$123.71	$123.71	$123.71
Family Cost Per Check with Year Round Deductions		$29.69	$42.55	$45.77
Family Cost Per Check with 16 Pay Perids Deductions		$44.53	$63.83	$68.66

VISION COVERAGE

Employee Only	**$7.54/month**
Employee + 1	**$12.06/month**
Employee + Children	**$12.31/month**
Family	**$19.84/month**

*Insurance premiums for employees primarily working on student contact days are divided equally over 16 pay periods during the school year. Year-round and school year only staff pay the same total amount for insurance premiums over a 12 month period. Staff on 16 pay period deductions include those in the following contracts: Educational Assistants, Community Education Staff, Nurses, Child Nutrition Staff, Other Staff, non-year round Office Employees, and COTA/Speech Language.

2026 INSURANCE PREMIUM RATE SCHEDULE

Administration; Community Services Coordinators; Confidential; Custodians; Head Custodians; Child Nutrition; Maintenance/Grnds/Electrical Coordinators; Nurses; COTA/Speech Language; Office Employees; Other Staff Principals; Superintendent; Technology; Educational Assistants *

HEALTH INSURANCE - BCBS of MN - Rates Effective January 1, 2026 through December 31, 2026

Option 1 HEALTH INSURANCE: $1500/$3000 CMM Plan

COST PER MONTH:		**A: 6-8 hrs/dy 30-40 hrs/wk**	**B: 5-<6 hrs/dy 25-<30 hrs/wk**	**C: 4-<5 hrs/dy 20-<25 hrs/wk**
SINGLE	**Employee Share:**	**$241.77**	**$527.45**	**$598.86**
	Board Contribution:	$714.19	$428.51	$357.10
	Total Premium:	$955.96	$955.96	$955.96
Single Cost Per Check with Year Round Deductions		$120.89	$263.73	$299.43
Single Cost Per Check with 16 Pay Periods Deductions		$181.33	$395.59	$449.15
FAMILY	**Employee Share:**	**$736.36**	**$1,605.10**	**$1,822.28**
	Board Contribution:	$2,171.84	$1,303.10	$1,085.92
	Total Premium:	$2,908.20	$2,908.20	$2,908.20
Family Cost Per Check with Year Round Deductions		$368.18	$802.55	$911.14
Family Cost Per Check with 16 Pay Periods Deductions		$552.27	$1,203.83	$1,366.71

Option 2 **HEALTH INSURANCE: Health Reimbursement Account**

COST PER MONTH:		**A: 6-8 hrs/dy 30-40 hrs/wk**	**B: 5-<6 hrs/dy 25-<30 hrs/wk**	**C: 4-<5 hrs/dy 20-<25 hrs/wk**
	Total Premium:	$948.77	$948.77	$948.77
	Board Contribution:	$714.19	$428.51	$357.10
	HRA Funding	$83.33	$83.33	$83.33
***	Net District Contribution	$630.86	$345.18	$273.77
SINGLE	**Employee Share:**	**$317.91**	**$603.59**	**$675.01**
Single Cost Per Check with Year Round Deductions		$158.96	$301.80	$337.51
Single Cost Per Check with 16 Pay Periods Deductions		$238.43	$452.69	$506.26
	Total Premium:	$2,884.58	$2,884.58	$2,884.58
	Board Contribution:	$2,171.84	$1,303.10	$1,085.92
	HRA Funding	$166.67	$166.67	$166.67
****	Net District Contribution	$2,005.17	$1,136.43	$919.25
FAMILY	**Employee Share:**	**$879.41**	**$1,748.15**	**$1,965.33**
Family Cost Per Check with Year Round Deductions		$439.71	$874.08	$982.67
Family Cost Per Check with 16 Pay Periods Deductions		$659.56	$1,311.11	$1,474.00

District Funds 50% of the HRA Deductible ($1,000/single or $2,000/family)

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****Family = $2,000.00/12 = $166.67/month contribution towards HRA. Regular monthly contribution by the District toward monthly premium is $2,171.84. The $166.67/mo. that is contributed towards the HRA is subtracted from the regular monthly contribution paid by the District towards premium. $2,171.84 - $166.67 = $2,005.17 to be paid by the District towards the monthly premium.

Administration; Community Services Coordinators; Confidential; Custodians; Head Custodians; Child Nutrition; Maintenance/Grnds/Electrical Coordinators; Nurses; COTA/Speech Language; Office Employees; Other Staff; Principals; Superintendent; Technology; Educational Assistants *

DENTAL INSURANCE: Delta Dental - Rates Effective January 1, 2026 through December 31, 2026

COST PER MONTH:

		A: 6-8 hrs/dy 30-40 hrs/wk	B: 5-<6 hrs/dy 25-<30 hrs/wk	C: 4-<5 hrs/dy 20-<25 hrs/wk
SINGLE	**Employee Share:**	**$13.77**	**$25.05**	**$27.87**
	Board Contribution:	$28.20	$16.92	$14.10
	Total Premium:	$41.97	$41.97	$41.97
Single Cost Per Check with Year Round Deductions		$6.89	$12.53	$13.94
Single Cost Per Check with 16 Pay Perids Deductions		$10.33	$18.79	$20.90

FAMILY	**Employee Share:**	**$59.37**	**$85.11**	**$91.54**
	Board Contribution:	$64.34	$38.60	$32.17
	Total Premium:	$123.71	$123.71	$123.71
Family Cost Per Check with Year Round Deductions		$29.69	$42.55	$45.77
Family Cost Per Check with 16 Pay Perids Deductions		$44.53	$63.83	$68.66

VISION COVERAGE

Employee Only	**$7.54/month**
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Family	**$19.84/month**

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