WPUSD Active Employee Rate Sheet 2021-2022 (effective 7/1/21)

Must be at least 50% or 20 hours per week to be eligible. District contributions are prorated by FTE/daily hours for those employees working less than 1 FTE or less than 8 hours per day. Full-time cap is \$1,201.99 per month. Prorated cap examples: If 80% FTE, \$1201.99 x 80% = \$961.59. If 5.66 hours per day, \$150.24 x 5.66 hours = \$850.41 monthly. If hourly, but not working each day, daily hours are averaged over 5 days. Total medical, dental and/or vision minus cap = employee out of pocket, if applicable.

SUTTER HEALTH PLUS	(see map for	coverage areas)
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HMO (Office \$25/Rx\$10/\$25) MONTHLY PREMIUM Employee only \$ 879.00 Employee plus spouse \$ 1,758.00 Employee plus child/children \$ 2,065.00 Kaiser High Deductible (\$2,000 single deductible/\$4,000 family deductible) Employee plus family \$ 617.00 Employee plus spouse \$ 617.00 \$ 936.00 Employee plus child/children \$ 936.00 Employee plus family \$ 1,245.00 DELTA DENTAL (all dependents covered under composite rate) MONTHLY PREMIUM Employee only \$ 125.75 Employee plus spouse \$ 125.75 Employee plus child/children \$ 125.75 Employee plus child/children \$ 125.75	HMO (Office \$25 / Rx \$10/\$30/\$60)	MONTHLY PREMIUM
Employee plus child/children S	Employee only	\$ 854.00
Employee plus family S		
High Deductible Mid HMO (\$1,500 single deductible/\$3,000 family deductible Employee only \$ 615.00		
Employee plus spouse \$ 1,260.00		\$ 2,006.00
Employee plus schild/children \$ 932.00		
Employee plus child/children \$ 932.00		
Employee plus family \$ 1,440,00		
High Deductible HMO (\$2,500 single deductible/\$5,000 family deductible) Employee only \$ 545.00		
Employee plus S		\$ 1,440.00
Employee plus spouse \$ 1,086.00		¢ 545.00
Employee plus child/children \$ 1,275.00		
Employee plus family \$ 1,275.00		
WESTERN HEALTH ADVANTAGE (see map for coverage areas) HMO (Office \$25 / Rx \$10/\$30/\$50) Employee only \$ 758.00 Employee plus spouse Employee plus spouse \$ 1,515.00 Employee plus child/children \$ 1,152.00 Employee plus family Employee plus family \$ 1,780.00 Employee plus family \$ 1,780.00 WHA High Deductible Mid HMO (\$1,800 single ded./\$3,600 family ded.) Employee plus spouse \$ 1,145.00 Employee plus child/children \$ Employee plus spouse \$ 1,145.00 Employee plus child/children \$ 868.00 Employee plus child/children \$ Employee plus family \$ 1,337.00 Employee plus spouse \$ 487.00 Employee plus spouse \$ Propose plus family \$ 1,133.00 \$ 737.00 KAISER HMO (Office \$25/Rx\$10/\$25) Employee plus family \$ 1,758.00 MONTHLY PREMIUM KAISER HMO (Office \$25/Rx\$10/\$25) Employee plus family \$ 2,065.00 Kaiser High Deductible (\$2,000 single deductible/\$4,000 family deductible) Employee plus family \$ 2,065.00 Kaiser High Deductible (\$2,000 single deductible/\$4,000 family deductible) Employee only \$ 617.00 Employee plus spouse \$ 1,230.00 Employee plus family \$ 1,435.00 DELTA DENTAL (all dependents covered under composite rate) MONTHLY PREMIUM Employee plus family \$ 1,25.75 Employee plus child/children \$		
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Employee puls spouse S 758.00		MONTHLY DREMIUM
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Employee only Sample A87.00		
Employee only \$ 487.00		,,,,,
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Employee plus child/children \$ 737.00		
KAISER HMO (Office \$25/Rx\$10/\$25) MONTHLY PREMIUM Employee only \$ 879.00 Employee plus spouse \$ 1,758.00 Employee plus child/children \$ 2,065.00 Kaiser High Deductible (\$2,000 single deductible/\$4,000 family deductible) Employee plus family \$ 617.00 Employee plus spouse \$ 1,230.00 617.00 Employee plus spouse \$ 1,230.00 Employee plus family \$ 936.00 Employee plus family \$ 1,245.00 DELTA DENTAL (all dependents covered under composite rate) MONTHLY PREMIUM Employee plus spouse \$ 125.75 Employee plus child/children \$ 125.75 Employee plus child/children \$ 125.75 VISION SERVICE PLAN (VSP) (all dependents covered under composite rate) MONTHLY PREMIUM Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80		
Monthly Premium	Employee plus family	\$ 1,133.00
Employee only \$ 879.00	KAISER	
Employee plus spouse \$ 1,758.00	HMO (Office \$25/Rx\$10/\$25)	MONTHLY PREMIUM
Employee plus child/children \$ 1,336.00		
Employee plus family \$ 2,065.00		
Employee only Semployee Semployee only Semployee		
Employee only \$ 617.00		\$ 2,065.00
Employee plus spouse \$ 1,230.00 Employee plus child/children \$ 936.00 Employee plus family \$ 1,445.00 DELTA DENTAL (all dependents covered under composite rate) MONTHLY PREMIUM Employee only \$ 125.75 Employee plus spouse \$ 125.75 Employee plus child/children \$ 125.75 Employee plus family \$ 125.75 VISION SERVICE PLAN (VSP) (all dependents covered under composite rate) MONTHLY PREMIUM Employee only \$ 20.80 Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80 Employee plus child/children \$ 20.80		
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Employee plus spouse \$ 125.75 Employee plus child/children \$ 125.75 Employee plus family \$ 125.75 VISION SERVICE PLAN (VSP) (all dependents covered under composite rate) MONTHLY PREMIUM Employee only \$ 20.80 Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80	DELTA DENTAL (all dependents covered under composite rate)	
Employee plus child/children \$ 125.75 Employee plus family \$ 125.75 VISION SERVICE PLAN (VSP) (all dependents covered under composite rate)		
Employee plus family \$ 125.75 VISION SERVICE PLAN (VSP) (all dependents covered under composite rate)		
VISION SERVICE PLAN (VSP) (all dependents covered under composite rate) Employee only \$ 20.80 Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80		
Employee only \$ 20.80 Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80	Employee plus family	\$ 125.75
Employee only \$ 20.80 Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80	VISION SERVICE PLAN (VSP) (all dependents covered under composite rate)	MONTHLY PREMIUM
Employee plus spouse \$ 20.80 Employee plus child/children \$ 20.80		
Employee plus child/children \$ 20.80		

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BLUE SHIELD (only if living outside Kaiser, Sutter Health and Western Health service areas)

Trio HMO (\$1,500 single deductible/\$3,000 family deductible)	MONTHLY PREMIUM
Employee only	\$ 756.00
Employee plus spouse	\$ 1,512.00
Employee plus child/children	\$ 1,156.00
Employee plus family	\$ 1,776.00
PPO Savings 2700 (\$2,700 single deductible/\$5,200 family deductible)	
Employee only	\$ 691.00

Employee only	Ψ	091.00
Employee plus spouse	\$	1,382.00
Employee plus child/children	\$	1,057.00
Employee plus family	\$	1,623.00

PPO Savings 4000 (\$4,000 single deductible/\$8,000 family deductible)	
Employee only	\$ 633.00
Employee plus spouse	\$ 1,264.00
Employee plus child/children	\$ 967.00
Employee plus family	\$ 1,484.00

DELTA DENTAL (all dependents covered under composite rate)	MONTHLY PREMIUM
Employee only	\$ 125.75
Employee plus spouse	\$ 125.75
Employee plus child/children	\$ 125.75
Employee plus family	\$ 125.75

VISION SERVICE PLAN (VSP) (all dependents covered under composite rate)		MONTHLY PREMIUM
Employee only	\$	20.80
Employee plus spouse	\$	20.80
Employee plus child/children	\$	20.80
Employee plus family	\$	20.80