2023-2024 Certified Insurance Rate Worksheet

Medical Plans	Rate**
Plan 1 w/Pharmacy (Moda network; $400-$500 deductible)	$ 1,826.00
Plan 2 w/Pharmacy (Moda network; $800-$900 deductible)	$ 1,694.00
Plan 3 w/Pharmacy (Moda network; $1200-$1300 deductible)	$ 1,589.00
Plan 4 w/Pharmacy (Moda network; $1600-$1700 deductible)	$ 1,501.00
Plan 5 w/Pharmacy (Moda network; $2000-$2100 deductible)	$ 1,386.00
Plan 7 *optional HSA* (Moda network; $2000-$2100 deductible)	$ 1,320.00
Kaiser Plan 1 (Kaiser network only; $0 deductible, no out of network benefits)	$ 1,650.00
Kaiser Plan 2b (Kaiser network only; $1,200 deductible; no out of network benefits)	$ 1,326.00
Kaiser Plan 3 *optional HSA* (Kaiser network only; $1,600 deductible; no out of network benefits)	$ 1,007.00

Dental Plans	Rate**
Plan 1 w/ortho ($2200 annual max benefit / $1800 ortho lifetime max)	$ 160.00
Plan 5 w/ortho ($1700 annual max benefit / $1800 ortho lifetime max)	$ 141.00
Plan 6 no ortho ($1200 annual max benefit)	$ 102.00
Exclusive PPO plan (no out of network benefit)	$ 93.00
Exclusive PPO Incentive plan (no out of network benefit)	$ 138.00
Kaiser Dental (Kaiser facility only; $4,000 annual max benefit; Ortho copays)	$ 169.00
Willamette Dental w/ortho (WDG facility only; no max benefit, Ortho copays)	$ 121.00

Note: If you waive dental coverage, you will have limited benefits available the following year.

Vision Plans	Rate**
Opal ($600 annual max benefit)	$ 50.00
Pearl ($400 annual max benefit)	$ 41.00
Quartz ($250 annual max benefit)	$ 29.00
VSP Choice Plan (co-pay for exam, lenses, $150 frame allowance)	$ 17.00
VSP Choice Plus Plan (co-pay for exam, lenses, $300 frame allowance)	$ 35.00
Kaiser Vision (Kaiser facility only; $250 annual max benefit)	$ 20.00

* **IF** you are enrolling in Plan 7 or Kaiser 3, **AND** the district contribution is greater than your total of selected plans, the district will deposit the remainder of your contribution into your personal H.S.A account. This does not include funds from the CEA reserve.

** all rates are composite -- same premium for Employee only or with dependents

Monthly Deduction Worksheet

Choose ONE Medical Plan	$
Choose ONE Dental Plan	$
Choose ONE Vision Plan	$
Total of selected plans	$
SUBTRACT District Contribution (see below) *	$
SUBTRACT CEA Reserve Contribution (see below)	$
Employee paycheck deduction **(monthly)**	$

FTE	District Contribution:	CEA Reserve Contribution:
0.50	$ 713.00	$ 75.00
0.60	$ 855.00	$ 75.00
0.67	$ 955.00	$ 75.00
0.70	$ 998.00	$ 75.00
0.75	$ 1,069.00	$ 75.00
0.80	$ 1,140.00	$ 75.00
0.83	$ 1,183.00	$ 75.00
0.90	$ 1,283.00	$ 75.00
1.00	$ 1,425.00	$ 75.00