

District Contribution for
Medical/Vision
is \$1,101.92

**WASHINGTON UNIFIED SCHOOL DISTRICT
CLASSIFIED BENEFIT RATES
EFFECTIVE JANUARY 2020 – DECEMBER 2020**

District Contribution for
Dental
is \$68.79/Month

Monthly Total Cost:

KAISER - HMO		
Employee	W/1 Dependent	Family Rate
\$887.96	\$1,775.92	\$2,512.93

KAISER - HDHP		
Employee	W/1 Dependent	Family Rate
\$728.18	\$1,456.37	\$2,060.76

Monthly Employee Cost – KAISER HMO

Employee	W/1 Dependent	Family Rate
\$0.00	\$674.00	\$1,411.01
\$0.00	\$708.44	\$1,445.45
\$0.00	\$742.87	\$1,479.88
\$0.00	\$777.31	\$1,514.32
\$0.00	\$811.74	\$1,548.75
\$0.00	\$846.18	\$1,583.19
\$0.00	\$880.61	\$1,617.62
\$27.09	\$915.05	\$1,652.06
\$61.52	\$949.48	\$1,686.49
\$95.95	\$983.92	\$1,720.93
\$130.39	\$1,018.35	\$1,755.36
\$164.83	\$1,052.79	\$1,789.80
\$199.26	\$1,087.22	\$1,824.23
\$233.70	\$1,121.66	\$1,858.67
\$268.13	\$1,156.09	\$1,893.10
\$302.57	\$1,190.53	\$1,927.54
\$337.00	\$1,224.96	\$1,961.97
\$371.44	\$1,259.40	\$1,996.41
\$405.87	\$1,293.83	\$2,030.84
\$440.31	\$1,328.27	\$2,065.28
\$474.74	\$1,362.70	\$2,099.71

Monthly Employee Cost – KAISER HDHP

Employee	W/1 Dependent	Family Rate
\$0.00	\$354.45	\$958.84
\$0.00	\$388.89	\$993.28
\$0.00	\$423.32	\$1,027.71
\$0.00	\$457.76	\$1,062.15
\$0.00	\$492.19	\$1,096.58
\$0.00	\$526.63	\$1,131.02
\$0.00	\$561.06	\$1,165.45
\$0.00	\$595.50	\$1,199.89
\$0.00	\$629.93	\$1,234.32
\$0.00	\$664.37	\$1,268.76
\$0.00	\$698.80	\$1,303.19
\$5.04	\$733.24	\$1,337.63
\$39.48	\$767.67	\$1,372.06
\$73.91	\$802.11	\$1,406.50
\$108.35	\$836.54	\$1,440.93
\$142.79	\$870.98	\$1,475.37
\$177.22	\$905.41	\$1,509.80
\$211.66	\$939.85	\$1,544.24
\$246.09	\$974.28	\$1,578.67
\$280.53	\$1,008.72	\$1,613.11
\$314.96	\$1,043.15	\$1,647.54

Hours/Day	%FTE
8	100%
7.75	96.875%
7.5	93.75%
7.25	90.625%
7	87.5%
6.75	84.375%
6.5	81.25%
6.25	78.125%
6	75%
5.75	71.875%
5.5	68.75%
5.25	65.63%
5	62.5%
4.75	59.375%
4.5	56.25%
4.25	53.125%
4	50%
3.75	46.875%
3.5	43.75%
3.25	40.625%
3	37.5%

Monthly Total Cost:

WESTERN HEALTH - HMO		
Employee	W/1 Dependent	Family Rate
\$916.74	\$1,823.90	\$2,576.87

WESTERN HEALTH - HSA		
Employee	W/1 Dependent	Family Rate
\$693.70	\$1,380.16	\$1,949.92

Monthly Employee Cost – WHA HMO

Employee	W/1 Dependent	Family Rate
\$0.00	\$721.98	\$1,474.95
\$0.00	\$756.42	\$1,509.39
\$0.00	\$790.85	\$1,543.82
\$0.00	\$825.29	\$1,578.26
\$0.00	\$859.72	\$1,612.69
\$0.00	\$894.16	\$1,647.13
\$21.43	\$928.59	\$1,681.56
\$55.87	\$963.03	\$1,716.00
\$90.30	\$997.46	\$1,750.43
\$124.74	\$1,031.90	\$1,784.87
\$159.17	\$1,066.33	\$1,819.30
\$193.55	\$1,100.71	\$1,853.68
\$228.04	\$1,135.20	\$1,888.17
\$262.48	\$1,169.64	\$1,922.61
\$296.91	\$1,204.07	\$1,957.04
\$331.35	\$1,238.51	\$1,991.48
\$365.78	\$1,272.94	\$2,025.91
\$400.22	\$1,307.38	\$2,060.35
\$434.65	\$1,341.81	\$2,094.78
\$469.09	\$1,376.25	\$2,129.22
\$503.52	\$1,410.68	\$2,163.65

Monthly Employee Cost – WHA HSA

Employee	W/1 Dependent	Family Rate
\$0.00	\$278.24	\$848.00
\$0.00	\$312.68	\$882.44
\$0.00	\$347.11	\$916.87
\$0.00	\$381.55	\$951.31
\$0.00	\$415.98	\$985.74
\$0.00	\$450.42	\$1,020.18
\$0.00	\$484.85	\$1,054.61
\$0.00	\$519.29	\$1,089.05
\$0.00	\$553.72	\$1,123.48
\$0.00	\$588.16	\$1,157.92
\$0.00	\$622.59	\$1,192.35
\$0.00	\$656.97	\$1,226.73
\$5.00	\$691.46	\$1,261.22
\$39.43	\$725.90	\$1,295.66
\$73.87	\$760.33	\$1,330.09
\$108.31	\$794.77	\$1,364.53
\$142.74	\$829.20	\$1,398.96
\$177.18	\$863.64	\$1,433.40
\$211.61	\$898.07	\$1,467.83
\$246.05	\$932.51	\$1,502.27
\$280.48	\$966.94	\$1,536.70

Hours/Day	%FTE
8	100%
7.75	96.875%
7.5	93.75%
7.25	90.625%
7	87.5%
6.75	84.375%
6.5	81.25%
6.25	78.125%
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Medical/Vision
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EFFECTIVE JANUARY 2020 – DECEMBER 2020**

District Contribution for
Dental
is \$68.79/Month

Monthly Total Cost:

DELTA DENTAL		
Employee	W/1 Dependent	Family Rate
\$75.02	\$135.04	\$195.06

Monthly Employee Cost – DELTA DENTAL

Hours/Day	%FTE
8	100%
7.75	96.875%
7.5	93.75%
7.25	90.625%
7	87.5%
6.75	84.375%
6.5	81.25%
6.25	78.125%
6	75%
5.75	71.875%
5.5	68.75%
5.25	65.63%
5	62.5%
4.75	59.375%
4.5	56.25%
4.25	53.125%
4	50%
3.75	46.875%
3.5	43.75%
3.25	40.625%
3	37.5%

Employee	W/1 Dependent	Family Rate
6.23	66.25	126.27
8.38	68.40	128.42
10.53	70.55	130.57
12.68	72.70	132.72
14.83	74.85	134.87
16.98	77.00	137.02
19.13	79.15	139.17
21.28	81.30	141.32
23.43	83.45	143.47
25.58	85.60	145.62
27.73	87.75	147.77
29.88	89.89	149.91
32.03	92.05	152.07
34.18	94.20	154.22
36.33	96.35	156.37
38.48	98.50	158.52
40.63	100.65	160.67
42.77	102.79	162.81
44.92	104.94	164.96
47.07	107.09	167.11
49.22	109.24	169.26

Monthly Total Cost:

SUPERIOR VISION - BASIC		
Employee	W/1 Dependent	Family Rate
\$4.95	\$9.63	\$16.93

Monthly Total Cost:

SUPERIOR VISION – BUY UP		
Employee	W/1 Dependent	Family Rate
\$7.83	\$15.22	\$26.68

*Employee cost for vision coverage is dependent on medical benefit selection. Any leftover amount after district contribution to medical benefit (up to \$1,101.94/month) will be applied to vision coverage.

Deductions are taken out 10 times per year, August through May