KIMBERLY SCHOOL DISTRICT #414 2026-2027 MONTHLY AMOUNTS

FULL BENEFITS (30+ hours per week)

MEDICAL - Select Health Gold $2000 - includes COBRA & EAP

$2000 Deductible/$3500max out of pocket; 80/50 Coinsurance

	Medical Total Cost	Amount Dist Pays NO Wellness Exam	Amount Dist Pays w/Wellness Exam	**Payroll Deduction NO Wellness Exam**	**Payroll Deduction w/ Wellness Exam**	*OPTIONAL VISION Blue Cross VSP Option*	*OPTIONAL DENTAL Blue Cross Dental* **Traditional PPO**	*OPTIONAL DENTAL Dental Blue Connect* **Willamette**
Employee	$816.30	$482.48	$775.90	**$333.82**	**$40.40**	$9.85	$33.90	$55.70
Empl/Child	$1,252.50	$482.48	$775.90	**$770.02**	**$476.60**	$15.00	$57.65	$94.55
Empl/Children	$1,466.40	$482.48	$775.90	**$983.92**	**$690.50**	$25.75	$101.85	$166.82
Empl/Spouse	$1,925.20	$482.48	$775.90	**$1,442.72**	**$1,149.30**	$15.00	$65.30	$107.02
Family	$2,398.80	$482.48	$775.90	**$1,916.32**	**$1,622.90**	$25.75	$117.35	$192.18

MEDICAL - Select Health Gold $3000 - includes COBRA & EAP

$3000 Deductible/$4500max out of pocket; 80/50 Coinsurance

	Medical Total Cost	Amount Dist Pays NO Wellness Exam	Amount Dist Pays w/Wellness Exam	**Payroll Deduction NO Wellness Exam**	**Payroll Deduction w/ Wellness Exam**	*OPTIONAL VISION Blue Cross VSP Option*	*OPTIONAL DENTAL Blue Cross Dental* **Traditional PPO**	*OPTIONAL DENTAL Dental Blue Connect* **Willamette**
Employee	$764.40	$482.48	$775.90	**$281.92**	**-$11.50**	$9.85	$33.90	$55.70
Empl/Child	$1,172.70	$482.48	$775.90	**$690.22**	**$396.80**	$15.00	$57.65	$94.55
Empl/Children	$1,372.70	$482.48	$775.90	**$890.22**	**$596.80**	$25.75	$101.85	$166.82
Empl/Spouse	$1,802.40	$482.48	$775.90	**$1,319.92**	**$1,026.50**	$15.00	$65.30	$107.02
Family	$2,245.70	$482.48	$775.90	**$1,763.22**	**$1,469.80**	$25.75	$117.35	$192.18

MEDICAL - Select Health Silver 3500 (HSA Qualified) - includes COBRA & EAP

$3500 Deductible/$5700max out of pocket; 70/50 Coinsurance

	Medical Total Cost	Amount Dist Pays NO Wellness Exam	Amount Dist Pays w/Wellness Exam	**Payroll Deduction NO Wellness Exam**	**Payroll Deduction w/ Wellness Exam**	*OPTIONAL VISION Blue Cross VSP Option*	*OPTIONAL DENTAL Blue Cross Dental* **Traditional PPO**	*OPTIONAL DENTAL Dental Blue Connect* **Willamette**
Employee	$693.60	$482.48	$775.90	**$211.12**	**-$82.30**	$9.85	$33.90	$55.70
Empl/Child	$1,063.90	$482.48	$775.90	**$581.42**	**$288.00**	$15.00	$57.65	$94.55
Empl/Children	$1,245.50	$482.48	$775.90	**$763.02**	**$469.60**	$25.75	$101.85	$166.82
Empl/Spouse	$1,635.00	$482.48	$775.90	**$1,152.52**	**$859.10**	$15.00	$65.30	$107.02
Family	$2,037.10	$482.48	$775.90	**$1,554.62**	**$1,261.20**	$25.75	$117.35	$192.18

*The remaining amount (in red) may be used for optional vision coverage, dental coverage, and/or health savings account (HSA).

If optional vision coverage, dental coverage, and/or health savings account (HSA) is declined the remaining benefit will be forfeited. A spouse account HSA contribution is no longer allowed due to IRS laws.

NOTE: You may take vision or dental insurance without taking medical insurance. PLEASE SEE BACK FOR OPTION COMPARISONS & SPECIAL NOTICE

Medical	Select Health Gold $2000		Select Health Gold $3000		Select Health Silver HSA $3500	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible - Individual	$2,000	$3,000	$3,000	$4,000	$3,500	$5,000
Deductible - Family	$4,000	$6,000	$6,000	$8,000	$7,000	$10,000
Coinsurance Percentage	80%	60%	80%	60%	70%	50%
Out Of Pocket - Individual	$3,500	$5,000	$4,500	$6,000	$5,700	$7,000
Out Of Pocket Maximum - Family	$7,000	$10,000	$9,000	$12,000	$11,400	$14,000
Physician Office Visits:*	$30 Copay	Ded & Co-Ins	$30 Copay	Ded & Co-Ins	Subject to Deductible & Co-Ins	
Specialty Office Visits/Urgent Care: *	$50 Copay	Ded & Co-Ins	$50 Copay	Ded & Co-Ins	Subject to Deductible & Co-Ins	
Intermountain Connect Care/Virtual Visits	100% covered/Ded & Co-Ins		100% covered/Ded & Co-Ins		100% after Ded	Subject to Deductible & Co-Ins
Emergency Room Services	$100 Copay-then Ded & Co-Ins		$100 Copay-then Ded & Co-Ins		$100 Copay-then Ded & Co-Ins	
Chiropractic Care	$30 Copay/ Ded & Co-Ins 20 Visits		$30 Copay/ Ded & Co-Ins 20 Visits		Ded/Co-Insurance 20 Visits	
Prescription Drug Coverage: **						
Preferred Generic	$10	$10	$10	$10	Ded/Co-Insurance	
Non-Preferred Generic	$10	$10	$10	$10	Ded/Co-Insurance	
Preferred Brand	$25 after RX Ded	$25 after RX Ded	$25 after RX Ded	$25 after RX Ded	Ded/Co-Insurance	
Non-Preferred Brand	$45 after RX Ded	$45 after RX Ded	$45 after RX Ded	$45 after RX Ded	Ded/Co-Insurance	
Preferred Specialty	$100 after RX Ded	$100 after RX Ded	$100 after RX Ded	$100 after RX Ded	Ded/Co-Insurance	
Non-Preferred Specialty	$100 after RX Ded	$100 after RX Ded	$100 after RX Ded	$100 after RX Ded	Ded/Co-Insurance	
Prescription Deductible	$250		$250		Medical Deductible*	
Prescription Individual Out of Pocket Max	Combined with Medical		Combined with Medical		Combined with Medical	
Mental Health / Chemical Dependency:						
Outpatient - Office Visits	$30 Copay	Ded & Co-Ins	$30 Copay	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Outpatient - Other Professional Services	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Inpatient - Facility & Professional Services	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Covered Preventive Care & Immunizations	100%	Ded & Co-Ins	100%	Ded & Co-Ins	100%	Ded & Co-Ins
Employee Assistance Program (EAP)	4 Visits		4 Visits		4 Visits	
COBRA Administration	E-Benefits		E-Benefits		E-Benefits	

Enhanced Rx For Preventive Drugs

Minor Lab/Xray Included in office copay

OPTIONAL VISION Blue Cross VSP Option
Exam Co-Pay $10 every 12 months
Lenses/Frames Co-Pay $25.00
Frames: $130 Allowance Every 24 months
Contact Lenses: $130 Every 12 months

OPTIONAL DENTAL Blue Cross Dental
Traditional PPO $50
Deductible $50
Preventive 100%
Basic 80%
Major 50%
Implants 50%
Annual Max $1250
No Orthodontics

OPTIONAL DENTAL Dental Blue Connect
Willamette No Deductible/No Annual Maximum
$15 Office Visit covers: Routine & Emergency Exams, Xrays, Teeth Cleaning, Fluoride Treatment, Sealants, Head & Neck Cancer Screening, Oral Hygiene Instruction, Periodontal Charting & Evaluation
$15 Filling copayment
$150 Porcelain-Metal Crown
$200 Complete Upper or Lower Denture
$150 Bridge/per tooth
$50 copay for Root Canal Therapy $75 copay for Osseous Surgery $25 copay for Root Planing
$15 copay - Routine Extraction $75 copay - Surgical Extraction
Orthodontia: Pre-Treatment $150 Comprehensive Treatment $1500
Must use Willamette Dental Providers

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan (with qualifying event), provided that you request enrollment within 30 days after your other coverage ends. In addition, if you are enrolled and have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your newly acquired dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

THINKING ABOUT RETIRING?

If you want to utilitze medical, vision, and/or dental insurance coverage after you retire - you and/or dependents must be covered on the district's medical, vision, and/or dental plan for at least 12 months prior to your retirement date.