

CLASSIFIED / MANAGEMENT / CONFIDENTIAL
MONTHLY PREMIUMS FOR 2026-2027

*Fringe contribution is based on level of medical enrollment
*50-74% positions receive a pro-rated fringe contribution to a full-time employee

* Classified Fringe - Fringe increase currently in negotiations	\$ 907.00	\$ 955.00	\$ 1,078.00
* Management/Confidential Fringe	\$ 982.97	\$ 1,206.23	\$ 1,550.12

Plan Year 1/1/26- 9/30/26	Single	2-Party	Family
Anthem PPO Plan A 80-E \$20 Deductible \$300 individual / \$600 family; 80% Office Visits \$20 Rx \$7 generic / \$25 brand	\$1,090.00	\$2,127.00	\$2,981.00
Anthem PPO Plan B 80-G \$30 Deductible \$500 individual / \$1000 family; 80% Office Visits \$30 Rx \$10 generic / \$35 Brand Brand name deductible \$200 indiv. / \$500 family	\$983.00	\$1,923.00	\$2,700.00
Anthem PPO Plan C 80-L \$30 Deductible \$2000 individual / \$4000 family; 80% Office Visits \$30 Rx \$10 generic / \$35 brand Brand name deductible \$200 indiv. / \$500 family	\$869.00	\$1,694.00	\$2,375.00
Anthem PPO Plan D 80-M \$40 Deductible \$3000 individual / \$6000 family; 80% Office Visits \$40 Rx \$9 generic / \$35 brand	\$798.00	\$1,548.00	\$2,162.00
Anthem PPO Plan E HSA 3400 Deductible \$3400 individual / \$6800 family; 90% Office Visits- Deductible needs to be met first Health Savings Account compatible Rx \$7 generic / \$25 brand (subject to deductible)	\$762.00	\$1,477.00	\$2,063.00
Anthem PPO Plan G Proactive Care Plan Platinum No Deductibles/No Co-Insurance - Copay Only Office Visits \$0 Rx \$9 generic / \$35 brand	\$1,012.00	1,975.00	2,772.00
Anthem PPO Plan I 2-Tier MEC 9000 Deductible \$9,000 individual / \$18,000 family Office Visits- Deductible needs to be met first Health Savings Account compatible <i>Employee & child/children ONLY</i>	\$624.00	\$1,192.00	\$1,192.00
Plan J Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	\$624.00	N/A	N/A
Plan Year 1/1/26- 9/30/26	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
DELTA DENTAL- Group #6736-0001 Plan A No Deductible, \$1,700/person max - Premier No Deductible, \$1,900/person max - PPO \$500 adult or child ortho max	\$46.60	\$82.86	\$119.67
DELTA DENTAL- Group #6736-0003 Plan B No Deductible, \$2,300/person max - Premier No Deductible, \$2,500/person max - PPO \$1,000 child ortho max (no adult coverage)	\$52.07	\$92.56	\$133.74
DELTA DENTAL- GROUP #6736-01001 Plan C No Deductible, \$2,700/person max - Premier No Deductible, \$2,900/person max - PPO This plan has implant coverage \$500 adult or child ortho max	\$59.17	\$105.23	\$151.51
DELTA DENTAL- GROUP #6736-01003 Plan D No Deductible, \$3,300/person max - Premier No Deductible, \$3,500/person max - PPO This plan has implant coverage \$1,000 child ortho max (no adult coverage)	\$66.11	\$117.55	\$169.81
VISION- Group #30071230 Plan Year 1/1/2026 to 9/30/2026 \$0 Deductible, \$0 co-pay, \$300 allowance Yearly exam, Frame/lens/contacts 12 months Light Care Benefit (coverage for non-prescription blue light and sunglasses) Sub-Group # 0001	\$10.28	\$16.72	\$26.50