CLASSIFIED / MANAGEMENT / CONFIDENTIAL
MONTHLY PREMIUMS FOR 2025

***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***	***$ 742.00***	***$ 790.00***	***$ 913.00***
**** Management/Confidential Fringe***	***$ 764.00***	***$ 975.00***	***$ 1,300.00***

Classified/Confidential/Management	**Single**	**2-Party**	**Family**
Plan Year 1/1/2025 to 12/31/2025			
Blue Shield (PPO) Plan A - $25	**$1,373.00**	**$2,743.00**	**$3,564.00**
Deductible $1,000 Individual / $2,000 Family			
Office Visits $25 - Rx $10 Generic / $45 Brand			
Blue Shield (PPO) Plan C - $40	**$1,016.00**	**$2,032.00**	**$2,641.00**
Deductible $1,650 Individual / $3,300 Family			
Office Visits $40 - Rx $10 Generic / $45 Brand			
Blue Shield (PPO) Plan E - $60	**$819.00**	**$1,635.00**	**$2,126.00**
Deductible $6000 - *Deductible must be met before any coverage*			
Office Visits $60 - Rx $25			
Blue Shield PPO Select Plan F			
Deductible $1,300 Individual/ $2,600 family	**$818.00**	**$1,627.00**	**$2,114.00**
Office Visits $25 - Rx $10 Generic/$45 Brand			
**No out of network coverage			

All Staff	**Single**	**2-Party**	**Family**
***Dental Plans -Two year commitment required**			
DELTA DENTAL- Group #6736-0001 Plan A	**$53.83**	**$95.72**	**$138.25**
$50/$150 Deductible, $1,200/person max - Premier			
$50/$150 Deductible, $1,400/person max - PPO			
$500 adult or child ortho max			
DELTA DENTAL- Group #6736-0003 Plan B	**$60.15**	**$106.93**	**$154.50**
$50/$150 Deductible, $1,800/person max - Premier			
$50/$150 Deductible, $2,000/person max - PPO			
$1,000 child ortho max (no adult coverage)			
DELTA DENTAL- GROUP #6736-01001 Plan C	**$68.36**	**$121.57**	**$175.03**
$50/$150 Deductible, $2,200/person max - Premier			
$50/$150 Deductible, $2,400/person max - PPO			
This plan has implant coverage. $500 adult or child ortho max.			
DELTA DENTAL- GROUP #6736-01003 Plan D	**$76.38**	**$135.80**	**$196.18**
$50/$150 Deductible, $2,800/person max - Premier			
$50/$150 Deductible, $3,000/person max - PPO			
This plan has implant coverage. $1,000 child ortho max (no adult coverage).			
VISION- Group #30071230	**$11.37**	**$18.48**	**$29.30**
$0 Deductible, $0 co-pay, $250 allowance			
Yearly exam, Frame/lens/contacts 12 months			
Sub-Group # 0001			