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***	***$ 932.00***	***$ 1,104.00***	***$ 1,321.00***
**** 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 B Deductible $3500 individual / $7000 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-Insruance - 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	**$624.00**	**$1,192.00** *Employee & child/children ONLY*	**$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	Single	2-Party	Family
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**