

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	\$ 907.00	\$ 955.00	\$ 1,078.00
* Management/Confidential Fringe	\$ 929.00	\$ 1,140.00	\$ 1,465.00

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 - <i>Deductible must be met before any coverage</i> Office Visits \$60 - Rx \$25			
Blue Shield PPO Select Plan F			
Deductible \$1,300 Individual/ \$2,600 family 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			