CLASSIFIED / MANAGEMENT / CONFIDENTIAL
MONTHLY PREMIUMS FOR 2026

***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***

Plan Year 1/1/26- 9/30/26	Single	2-Party	Family
Plan A 80-E $20 Deductible $300 individual / $600 family; 80% Office Visits $20 Rx $7 generic / $25 brand	**$958.00**	**$1,868.00**	**$2,618.00**
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	**$861.00**	**$1,684.00**	**$2,365.00**
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	**$761.00**	**$1,484.00**	**$2,080.00**
Plan D 80-M $40 Deductible $3000 individual / $6000 family; 80% Office Visits $40 Rx $9 generic / $35 brand	**$702.00**	**$1,360.00**	**$1,899.00**
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)	**$669.00**	**$1,297.00**	**$1,811.00**
Plan G Proactive Care Plan Platinum No Deductibles/No Co-Insruance - Copay Only Office Visits $0 Rx $9 generic / $35 brand	**$889.00**	**1,735.00**	**2,433.00**
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	**$542.00**	**$1,036.00** *Employee & child/children ONLY*	**$1,036.00**
Plan J Waiver Active Benefit Enrollment (WABE) No Medical Coverage Access to Value Added Plans	**$542.00**	**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	**$53.83**	**$95.72**	**$138.25**
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)	**$60.15**	**$106.93**	**$154.50**
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	**$68.36**	**$121.57**	**$175.03**
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)	**$76.38**	**$135.80**	**$196.18**
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	**$11.37**	**$18.48**	**$29.30**