

**CLASSIFIED / MANAGEMENT / CONFIDENTIAL
MONTHLY PREMIUMS FOR 2024**

*Fringe contribution is based on level of medical enrollment
*50-74% positions receive half of the fringe contribution based on the level of enrollment

* 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 1/1/2024 to 12/31/2024			
Blue Shield (PPO) Plan A - \$25	\$1,221.00	\$2,439.00	\$3,169.00
Deductible \$650 Individual / \$1,300 Family Office Visits \$25 - Rx \$7 Generic / \$45 Brand			
Blue Shield (PPO) Plan B - \$30	\$1,043.00	\$2,083.00	\$2,707.00
Deductible \$1000 Individual / \$2000 family Office Visits \$30 - Rx \$10 Generic/ \$45 Brand			
Blue Shield (PPO) Plan C - \$40	\$903.00	\$1,807.00	\$2,348.00
Deductible \$1500 Individual / \$3,000 Family Office Visits \$40 - Rx \$10 Generic / \$45 Brand			
Blue Shield (PPO) Plan D - \$50	\$883.00	\$1,764.00	\$2,295.00
Deductible \$2,500 Individual / \$5,000 family Office Visits \$50 - Rx \$10 Generic / \$45 Brand			
Blue Shield (PPO) Plan E - \$60	\$728.00	\$1,454.00	\$1,890.00
Deductible \$5000 - <i>Deductible must be met before any coverage</i> Office Visits \$60 - Rx \$25			
Blue Shield PPO Select Plan F	\$727.00	\$1,447.00	\$1,880.00
Deductible \$1,000 Individual/ \$2,000 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, \$200 allowance Yearly exam, Frame/lens/contacts 12 months Sub-Group # 0001			