CLASSIFIED / MANAGEMENT / CONFIDENTIAL
MONTHLY PREMIUMS FOR 2024

***Fringe contribution is based on level of medical enrollment *For 50-74% positions you will receive half of the below fringe contributions**

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

Classified/Confidential/Management	**Single**	**Double**	**Family**
Plan Year 1/1/2024 to 12/31/2024			
Blue Shield (PPO) Plan A - $25 Deductible $650 Individual / $1,300 Family Office Visits $25 - Rx $7 Generic / $45 Brand	**$1,221.00**	**$2,439.00**	**$3,169.00**
Blue Shield (PPO) Plan B - $30 Deductible $1000 Individual / $2000 family Office Visits $30 - Rx $10 Generic/ $45 Brand	**$1,043.00**	**$2,083.00**	**$2,707.00**
Blue Shield (PPO) Plan C - $40 Deductible $1500 Individual / $3,000 Family Office Visits $40 - Rx $10 Generic / $45 Brand	**$903.00**	**$1,807.00**	**$2,348.00**
Blue Shield (PPO) Plan D - $50 Deductible $2,500 Individual / $5,000 family Office Visits $50 - Rx $10 Generic / $45 Brand	**$883.00**	**$1,764.00**	**$2,295.00**
Blue Shield (PPO) Plan E - $60 Deductible $5000 - *Deductible must be met before any coverage* Office Visits $60 - Rx $25	**$728.00**	**$1,454.00**	**$1,890.00**
Blue Shield PPO Select Plan F Deductible $1,000 Individual/ $2,000 family Office Visits $25 - Rx $10 Generic/$45 Brand **No out of network coverage	**$727.00**	**$1,447.00**	**$1,880.00**

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