Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026* **Provider Network:**	**Current Plan BCN HMO $500 100%** **(Current Billed Ages)**		**Renewal Plan - BCN HMO $500 100%** **(Renewal Billed Ages)**		**BCN HMO 20% $500 Deductible**		**BCN HMO $1000 Deductible**	
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$5,000**	N/A	**$3,500**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$10,000**	N/A	**$7,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$9,100**	N/A	**$9,100**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$18,200**	N/A	**$18,200**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		$20	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$50**		**$40**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$350 after Deductible**		**$250 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$15 / $40**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $100**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Gold Option 1		BCN Gold Option 2	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$26,047.99**	**$312,575.88**	**$25,750.59**	**$309,007.08**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($1,470.74)**	**($17,648.88)**	**($1,768.14)**	**($21,217.68)**
% Change from Current			**17.08%**		**-5.34%**		**-6.43%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN HMO $1500 Deductible		BCN HMO $2000 Deductible	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,500**	N/A	**$2,000**	N/A
Family	$1,000	N/A	$1,000	N/A	**$3,000**	N/A	**$4,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$3,000**	N/A	**$2,500**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$6,000**	N/A	**$5,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$9,100**	N/A	**$9,100**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$18,200**	N/A	**$18,200**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$40**		**$40**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$250 after Deductible**		$150 after Deductible	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$10 / $30**		**$10 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $80**		**$60 / $80**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Gold Option 3		BCN Gold Option 4	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$25,403.60**	**$304,843.20**	**$24,917.35**	**$299,008.20**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($2,115.13)**	**($25,381.56)**	**($2,601.38)**	**($31,216.56)**
% Change from Current			**17.08%**		**-7.69%**		**-9.45%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN HMO $2500 Deductible		BCN HMO $3000 Deductible	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$2,500**	N/A	**$3,000**	N/A
Family	$1,000	N/A	$1,000	N/A	**$5,000**	N/A	**$6,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$3,500**	N/A	**$3,000**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$7,000**	N/A	**$6,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$9,100**	N/A	**$9,100**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$18,200**	N/A	**$18,200**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		**$50**		**$50**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		$150 after Deductible		$150 after Deductible	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$4 / $15		$4 / $15	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN Gold Option 5		BCN Gold Option 6	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$24,615.92**	**$295,391.04**	**$24,220.83**	**$290,649.96**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($2,902.81)**	**($34,833.72)**	**($3,297.90)**	**($39,574.80)**
% Change from Current			**17.08%**		**-10.55%**		**-11.98%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN HMO HSA $1700 Deductible Aggregate		BCN HMO HSA $2500 100% Deductible Aggregate	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,700**	N/A	**$2,500**	N/A
Family	$1,000	N/A	$1,000	N/A	**$3,400**	N/A	**$5,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$1,700**	N/A	**$4,500**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$3,400**	N/A	**$9,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$0*		$0*		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$30		$30		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$35		$35		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN H.S.A. Platinum		BCN H.S.A. Gold Option 2	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$26,470.54**	**$317,646.48**	**$22,959.33**	**$275,511.96**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($1,048.19)**	**($12,578.28)**	**($4,559.40)**	**($54,712.80)**
% Change from Current			**17.08%**		**-3.81%**		**-16.57%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN HMO HSA $3400 100% Deductible Embedded		BCN HMO HSA $4000 Deductible Embedded	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$3,400**	N/A	**$4,000**	N/A
Family	$1,000	N/A	$1,000	N/A	**$6,800**	N/A	**$8,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	**90%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$3,400**	N/A	**$7,500**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$6,800**	N/A	**$15,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**10% after Deductible**	
Virtual Care Visit	$0*		$0*		**0% after Deductible**		**10% after Deductible**	
Specialist Visit	$30		$30		**0% after Deductible**		**10% after Deductible**	
Urgent Care	$35		$35		**0% after Deductible**		**10% after Deductible**	
Emergency Room	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**10% after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		**10% after Deductible**	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		BCN H.S.A. Gold Option 3		BCN H.S.A. Silver Option 2	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$21,951.65**	**$263,419.80**	**$19,025.66**	**$228,307.92**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($5,567.08)**	**($66,804.96)**	**($8,493.07)**	**($101,916.84)**
% Change from Current			**17.08%**		**-20.23%**		**-30.86%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN HMO Elect Plus POS $250		BCN HMO Elect Plus POS $500	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN POS / Blue Card Traditional**		**BCN POS / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$250**	**$500**	$500	**$1,000**
Family	$1,000	N/A	$1,000	N/A	**$500**	**$1,000**	$1,000	**$2,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	**60%**	**80%**	**60%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	**$5,000**	**$10,000**
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$4,500**	**$9,000**	**$9,100**	**$18,200**
Family	$3,000	N/A	**$4,000**	N/A	**$9,000**	**$18,000**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$30**	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$30		**$50**	
Urgent Care	$35		$35		**$50**		**$50**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$150**		**$250**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$4 / $15		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Platinum Option 2		Blue Elect POS Gold Option 1	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$31,259.47**	**$375,113.64**	**$27,157.27**	**$325,887.24**
$ Change from Current			**$4,699.61**	**$56,395.32**	**$3,740.74**	**$44,888.88**	**($361.46)**	**($4,337.52)**
% Change from Current			**17.08%**		**13.59%**		**-1.31%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100%		Renewal Plan - BCN HMO $500 100%		BCN HMO Elect Plus POS $1000		BCN HMO Elect Plus POS $1500	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	BCN HMO / ER Services Only		BCN HMO / ER Services Only		BCN POS / Blue Cross Blue Shield		BCN POS / Blue Cross Blue Shield	
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$500	N/A	$500	N/A	$1,000	$2,000	$1,500	$3,000
Family	$1,000	N/A	$1,000	N/A	$2,000	$4,000	$3,000	$6,000
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	80%	60%	80%	60%
Coinsurance Max - Single	N/A	N/A	N/A	N/A	$5,000	$10,000	$5,000	$10,000
Coinsurance Max - Family	N/A	N/A	N/A	N/A	$10,000	$20,000	$10,000	$20,000
EE True Out of Pocket Max:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$1,500	N/A	$2,000	N/A	$9,100	$18,200	$9,100	$18,200
Family	$3,000	N/A	$4,000	N/A	$18,200	$36,400	$18,200	$36,400
In-Network Employee Copay:								
Office Visit	$20		$20		$30		$30	
Virtual Care Visit	$0*		$0*		$0*		$0*	
Specialist Visit	$30		$30		$50		$50	
Urgent Care	$35		$35		$50		$50	
Emergency Room	$150 after Deductible		$150 after Deductible		$250		$250	
Hospital Admission	0% after Deductible		0% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	Custom Select		Custom Select		Custom Select		Custom Select	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		$10 / $30		$10 / $30	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$60 / $80		$60 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect POS Gold Option 2		Blue Elect POS Gold Option 3	
Monthly / Annual Premium	$27,518.73	$330,224.76	$32,218.34	$386,620.08	$26,616.30	$319,395.60	$25,959.45	$311,513.40
$ Change from Current			$4,699.61	$56,395.32	($902.43)	($10,829.16)	($1,559.28)	($18,711.36)
% Change from Current			17.08%		-3.28%		-5.67%	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		BCN Elect Plus POS HSA $1700 Deductible ($0) Aggregate		BCN Elect Plus POS HSA $2500 Deductible ($0) Aggregate	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**BCN POS / Blue Cross Blue Shield**		**BCN POS / Blue Cross Blue Shield**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,700**	**$3,400**	**$2,500**	**$5,000**
Family	$1,000	N/A	$1,000	N/A	**$3,400**	**$6,800**	**$5,000**	**$10,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	**80%**	100%	**80%**
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$1,700**	**$3,400**	**$4,500**	**$9,000**
Family	$3,000	N/A	**$4,000**	N/A	**$3,400**	**$6,800**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$0*		$0*		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$30		$30		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$35		$35		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**0% after Deductible**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**0% after Deductible**		**20% $200 Max. / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Blue Elect Plus H.S.A. POS Platinum		Blue Elect Plus H.S.A. POS Gold Option	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$27,329.09**	**$327,949.08**	**$23,530.85**	**$282,370.20**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($189.64)**	**($2,275.68)**	**($3,987.88)**	**($47,854.56)**
% Change from Current			**17.08%**		**-0.69%**		**-14.49%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		HAP HMO 500		HAP HMO 1000	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**HAP HMO / ER Services Only**		**HAP HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$2,500**	N/A	**$8,200**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$5,000**	N/A	**$16,400**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$35**	
Virtual Care Visit	$0*		$0*		$0**		$0**	
Specialist Visit	$30		$30		**$40**		**$60**	
Urgent Care	$35		$35		**$65**		**$65**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$200**		**$300**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5** / $15		**$5 / $25**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$30 / $60**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max / **50% $500 Max**		20% $200 Max / **50% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		HMO Platinum A050		HMO Gold B1	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$31,528.13**	**$378,337.56**	**$24,428.33**	**$293,139.96**
$ Change from Current			**$4,699.61**	**$56,395.32**	**$4,009.40**	**$48,112.80**	**($3,090.40)**	**($37,084.80)**
% Change from Current			**17.08%**		**14.57%**		**-11.23%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		HAP HMO 1200		HAP HMO 1500	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**HAP HMO / ER Services Only**		**HAP HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$1,200**	N/A	**$1,500**	N/A
Family	$1,000	N/A	$1,000	N/A	**$2,400**	N/A	**$3,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	**$4,000**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	**$8,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$8,200**	N/A	**$8,200**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$16,400**	N/A	**$16,400**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$35**		**$35**	
Virtual Care Visit	$0*		$0*		$0**		$0**	
Specialist Visit	$30		$30		**$60**		**$60**	
Urgent Care	$35		$35		**$65**		**$65**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$300**		**$300**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5 / $30**		**$5 / $25**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max / **50% $500 Max**		20% $200 Max / **50% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		HMO Gold B12		HMO Gold B15	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$26,042.00**	**$312,504.00**	**$23,848.33**	**$286,179.96**
$ Change from Current			**$4,699.61**	**$56,395.32**	**($1,476.73)**	**($17,720.76)**	**($3,670.40)**	**($44,044.80)**
% Change from Current			**17.08%**		**-5.37%**		**-13.34%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Priority Health HMO $0 100%		Priority Health HMO 250 100%	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**Priority Health HMO / ER Services Only**		**Priority Health HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$0**	N/A	**$250**	N/A
Family	$1,000	N/A	$1,000	N/A	**$0**	N/A	**$500**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$4,500**	N/A	**$5,000**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$9,000**	N/A	**$10,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$15**	
Virtual Care Visit	$0*		$0*		**$10**		**$10**	
Specialist Visit	$30		$30		$30		**$35**	
Urgent Care	$35		$35		**$75**		**$75**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$200**		**$250 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**$200 Copay per admission**		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Optimized**		**Optimized**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5 / $10**		**$5 / $10**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max / 20% $300 Max		20% $200 Max / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Priority HMO Platinum		Priority HMO Platinum P251	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$30,574.00**	**$366,888.00**	**$30,900.16**	**$370,801.92**
$ Change from Current			**$4,699.61**	**$56,395.32**	**$3,055.27**	**$36,663.24**	**$3,381.43**	**$40,577.16**
% Change from Current			**17.08%**		**11.10%**		**12.29%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Priority Health HMO 475 90%		Priority Health HMO 500	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**Priority Health HMO / ER Services Only**		**Priority Health HMO / ER Services Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	**$475**	N/A	$500	N/A
Family	$1,000	N/A	$1,000	N/A	**$950**	N/A	$1,000	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**90%**	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	**$5,500**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	**$11,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$2,250**	N/A	**$9,600**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$4,500**	N/A	**$19,200**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$30**	
Virtual Care Visit	$0*		$0*		**$10**		**$10**	
Specialist Visit	$30		$30		**$45**		**$60**	
Urgent Care	$35		$35		**$75**		**$85**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$300 after Deductible**		**$350 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**10% after Deductible**		**20% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Optimized**		**Optimized**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$5** / $15		$5 / $35	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$80 / $95	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		20% $200 Max / 20% $300 Max		**20% $250 Max / 20% $450 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		Priority HMO Platinum P47		PriorityHMO Gold G50	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$29,877.56**	**$358,530.72**	**$25,766.83**	**$309,201.96**
$ Change from Current			**$4,699.61**	**$56,395.32**	**$2,358.83**	**$28,305.96**	**($1,751.90)**	**($21,022.80)**
% Change from Current			**17.08%**		**8.57%**		**-6.37%**	

Medical Policy # 00125981-0001-0001 *Renewal Date: 11/1/2026*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		United Healthcare Choice EN-8X		United Healthcare Choice EN-8V	
Provider Network:								
In State / Out of State Residents	**BCN HMO / ER Services Only**		**BCN HMO / ER Services Only**		**United Healthcare Choice / ER Only**		**United Healthcare Choice / ER Only**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	**$2,000**	N/A	**$2,500**	N/A	**$2,000**	N/A
Family	$3,000	N/A	**$4,000**	N/A	**$5,000**	N/A	**$4,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$10**	
Virtual Care Visit	$0*		$0*		100% Covered		100% Covered	
Specialist Visit	$30		$30		**$50 or $100**		**$40 or $80**	
Urgent Care	$35		$35		**$25**		**$25**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$500 after Deductible**		**$500 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$4 / $15		$4 / $15		**$10**		**$10**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / **$105**		$40 / **$105**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	20% $200 Max. / 20% $300 Max		20% $200 Max. / 20% $300 Max		**$250 / $500**		**$250 / $500**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		**End of Month Age 26**		**End of Month Age 26**	
Pediatric Dental	Not Included		Not Included		Automatically Included		Automatically Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	BCN Platinum		BCN Platinum		N/A		N/A	
Monthly / Annual Premium	**$27,518.73**	**$330,224.76**	**$32,218.34**	**$386,620.08**	**$34,949.64**	**$419,395.68**	**$34,474.45**	**$413,693.40**
$ Change from Current			**$4,699.61**	**$56,395.32**	**$7,430.91**	**$89,170.92**	**$6,955.72**	**$83,468.64**
% Change from Current			**17.08%**		**27.00%**		**25.28%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		BCBSM PPO $500		BCBSM PPO $1000	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,000**	**$2,000**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**70%**	**50%**	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,000**	**$10,000**	**$5,000**	**$10,000**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$10,000**	**$20,000**	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$8,150**	**$16,300**	**$8,150**	**$16,300**
Family	$13,200	$26,400	$13,200	$26,400	**$16,300**	**$32,600**	**$16,300**	**$32,600**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$30**		**$30**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		**30% after Deductible**		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$20**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $100**		**$60 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max** / 25% $300 Max		**20% $200 Max** / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 1		SB PPO Gold Option 2	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,532.90**	**$54,394.80**	**$4,496.59**	**$53,959.08**
$ Change from Current			**$862.03**	**$10,344.36**	**($171.30)**	**($2,055.60)**	**($207.61)**	**($2,491.32)**
% Change from Current			**18.32%**		**-3.64%**		**-4.41%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80%		Renewal Plan - BCBSM PPO $250 80%		BCBSM PPO $1500		BCBSM PPO $2000	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	BCBS National PPO		BCBS National PPO		BCBS National PPO		BCBS National PPO	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$1,500**	**$3,000**	**$2,000**	**$4,000**
Family	$500	$1,000	$500	$1,000	**$3,000**	**$6,000**	**$4,000**	**$8,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$4,000**	**$8,000**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$8,000**	**$16,000**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$8,150**	**$16,300**	**$7,350**	**$14,700**
Family	$13,200	$26,400	$13,200	$26,400	**$16,300**	**$32,600**	**$14,700**	**$29,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$30**		**$30**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		**$250**		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$20**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $100**		**$60 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max** / 25% $300 Max		**20% $200 Max** / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 3		SB PPO Gold Option 4	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,360.55**	**$52,326.60**	**$4,290.85**	**$51,490.20**
$ Change from Current			**$862.03**	**$10,344.36**	**($343.65)**	**($4,123.80)**	**($413.35)**	**($4,960.20)**
% Change from Current			**18.32%**		**-7.31%**		**-8.79%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		BCBSM PPO $2500		BCBSM PPO $3000	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$2,500**	**$5,000**	**$3,000**	**$6,000**
Family	$500	$1,000	$500	$1,000	**$5,000**	**$10,000**	**$6,000**	**$12,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$7,000**	**$14,000**	$6,600	$13,200
Family	$13,200	$26,400	$13,200	$26,400	**$14,000**	**$28,000**	$13,200	$26,400
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$30**		**$30**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		$150		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$20**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60 / $100**		**$60 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max** / 25% $300 Max		**20% $200 Max** / 25% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB PPO Gold Option 5		SB PPO Gold Option 6	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,223.28**	**$50,679.36**	**$4,181.25**	**$50,175.00**
$ Change from Current			**$862.03**	**$10,344.36**	**($480.92)**	**($5,771.04)**	**($522.95)**	**($6,275.40)**
% Change from Current			**18.32%**		**-10.22%**		**-11.12%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		$1700 100% BCBSM PPO HSA Aggregate		$2500 100% BCBSM PPO HSA Aggregate	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$1,700**	**$3,400**	**$2,500**	**$5,000**
Family	$500	$1,000	$500	$1,000	**$3,400**	**$6,800**	**$5,000**	**$10,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**80%**	**100%**	**80%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$1,700**	**$5,400**	**$4,500**	**$9,000**
Family	$13,200	$26,400	$13,200	$26,400	**$3,400**	**$10,800**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Virtual Care Visit	$20		$20		**0% after Deductible**		**0% after Deductible**	
Specialist Visit	$40		$40		**0% after Deductible**		**0% after Deductible**	
Urgent Care	$60		$60		**0% after Deductible**		**0% after Deductible**	
Emergency Room	$150		$150		**0% after Deductible**		**0% after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**0% after Deductible**	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**0% after Deductible**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$60 / $150**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**0% after Deductible**		**20% $300 Max / 25% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB H.S.A. PPO Platinum		SB H.S.A. PPO Gold Option 2	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,732.63**	**$56,791.56**	**$4,085.18**	**$49,022.16**
$ Change from Current			**$862.03**	**$10,344.36**	**$28.43**	**$341.16**	**($619.02)**	**($7,428.24)**
% Change from Current			**18.32%**		**0.60%**		**-13.16%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		$3400 100% BCBSM PPO HSA Embedded		$4000 90% BCBSM PPO HSA Embedded	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**		**BCBS National PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$3,400**	**$6,800**	**$4,000**	**$8,000**
Family	$500	$1,000	$500	$1,000	**$6,800**	**$13,600**	**$8,000**	**$16,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**80%**	**90%**	**70%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$3,400**	**$8,800**	**$7,500**	**$15,000**
Family	$13,200	$26,400	$13,200	$26,400	**$6,800**	**$17,600**	**$15,000**	**$30,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**0% after Deductible**		**10% after Deductible**	
Virtual Care Visit	$20		$20		**0% after Deductible**		**10% after Deductible**	
Specialist Visit	$40		$40		**0% after Deductible**		**10% after Deductible**	
Urgent Care	$60		$60		**0% after Deductible**		**10% after Deductible**	
Emergency Room	$150		$150		**0% after Deductible**		**10% after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**10% after Deductible**	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**0% after Deductible**		**$20**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**0% after Deductible**		**$100 / $150**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**0% after Deductible**		**20% $300 Max / 25% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		SB H.S.A. PPO Gold Option 3		SB H.S.A. PPO Silver Option 2	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,934.59**	**$47,215.08**	**$3,398.42**	**$40,781.04**
$ Change from Current			**$862.03**	**$10,344.36**	**($769.61)**	**($9,235.32)**	**($1,305.78)**	**($15,669.36)**
% Change from Current			**18.32%**		**-16.36%**		**-27.76%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		BCN HMO Elect Plus POS $0		BCN HMO Elect Plus POS $250	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN POS / Blue Card Traditional**		**BCN POS / Blue Card Traditional**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$0**	**$250**	$250	$500
Family	$500	$1,000	$500	$1,000	**$0**	**$500**	$500	$1,000
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$3,000**	**$6,000**	**$4,500**	**$9,000**
Family	$13,200	$26,400	$13,200	$26,400	**$6,000**	**$12,000**	**$9,000**	**$18,000**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$20		$20		**$0***		**$0***	
Specialist Visit	$40		$40		**$30**		**$30**	
Urgent Care	$60		$60		**$35**		**$50**	
Emergency Room	$150		$150		$150		$150	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$4 / $15**		**$4 / $15**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max. / **20% $300 Max**		20% $200 Max. / **20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Platinum Option 1		Blue Elect POS Platinum Option 2	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,365.08**	**$52,380.96**	**$4,111.65**	**$49,339.80**
$ Change from Current			**$862.03**	**$10,344.36**	**($339.12)**	**($4,069.44)**	**($592.55)**	**($7,110.60)**
% Change from Current			**18.32%**		**-7.21%**		**-12.60%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		BCN HMO Elect Plus POS $500		BCN HMO Elect Plus POS $1000	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN POS / Blue Card Traditional**		**BCN POS / Blue Cross Blue Shield**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,000**	**$2,000**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,000**	**$10,000**	**$5,000**	**$10,000**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$10,000**	**$20,000**	**$10,000**	**$20,000**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$9,100**	**$18,200**	**$9,100**	**$18,200**
Family	$13,200	$26,400	$13,200	$26,400	**$18,200**	**$36,400**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$0***		**$0***	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		**$50**		**$50**	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		**$15 / $40**		$10 / **$30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $100**		**$60** / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max. / **20% $300 Max**		20% $200 Max. / **20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Gold Option 1		Blue Elect POS Gold Option 2	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,572.07**	**$42,864.84**	**$3,500.91**	**$42,010.92**
$ Change from Current			**$862.03**	**$10,344.36**	**($1,132.13)**	**($13,585.56)**	**($1,203.29)**	**($14,439.48)**
% Change from Current			**18.32%**		**-24.07%**		**-25.58%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		BCN HMO Elect Plus POS $1500		BCN HMO Elect Plus POS $2000	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**BCN POS / Blue Cross Blue Shield**		**BCN POS / Blue Cross Blue Shield**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$1,500**	**$3,000**	**$2,000**	**$4,000**
Family	$500	$1,000	$500	$1,000	**$3,000**	**$6,000**	**$4,000**	**$8,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	80%	60%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,000**	**$10,000**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$10,000**	**$20,000**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$9,100**	**$18,200**	**$7,350**	**$14,700**
Family	$13,200	$26,400	$13,200	$26,400	**$18,200**	**$36,400**	**$14,700**	**$29,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$0***		**$0***	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		**$50**		**$50**	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Tier 1 / 1A: Generic	$10		$10		$10 / **$30**		**$15 / $40**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$60** / $80		**$80 / $100**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max. / **20% $300 Max**		20% $200 Max. / **20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect POS Gold Option 3		Blue Elect POS Gold Option 4	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,414.52**	**$40,974.24**	**$3,368.38**	**$40,420.56**
$ Change from Current			**$862.03**	**$10,344.36**	**($1,289.68)**	**($15,476.16)**	**($1,335.82)**	**($16,029.84)**
% Change from Current			**18.32%**		**-27.42%**		**-28.40%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80%		Renewal Plan - BCBSM PPO $250 80%		BCN Elect Plus POS HSA $1700 Deductible ($0)		BCN Elect Plus POS HSA $2500 Deductible ($0)	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)		Aggregate		Aggregate	
In State / Out of State Residents	BCBS National PPO		BCBS National PPO		BCN POS / Blue Cross Blue Shield		BCN POS / Blue Cross Blue Shield	
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$250	$500	$250	$500	$1,700	$3,400	$2,500	$5,000
Family	$500	$1,000	$500	$1,000	$3,400	$6,800	$5,000	$10,000
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	80%	100%	80%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$6,600	$13,200	$6,600	$13,200	$1,700	$3,400	$4,500	$9,000
Family	$13,200	$26,400	$13,200	$26,400	$3,400	$6,800	$9,000	$18,000
In-Network Employee Copay:								
Office Visit	$20		$20		0% after Deductible		0% after Deductible	
Virtual Care Visit	$20		$20		0% after Deductible		0% after Deductible	
Specialist Visit	$40		$40		0% after Deductible		0% after Deductible	
Urgent Care	$60		$60		0% after Deductible		0% after Deductible	
Emergency Room	$150		$150		0% after Deductible		0% after Deductible	
Hospital Admission	20% after Deductible		20% after Deductible		0% after Deductible		0% after Deductible	
Employee In-Network RX Copay:					Rx Copays after Deductible		Rx Copays after Deductible	
Prescription Formulary Type	Custom Select		Custom Select		Custom Select		Custom Select	
Tier 1 / 1A: Generic	$10		$10		0% after Deductible		$15 / $40	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		0% after Deductible		$80 / $100	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		0% after Deductible		20% $200 Max. / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		Blue Elect Plus H.S.A. POS Platinum		Blue Elect Plus H.S.A. POS Gold Option	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,594.68**	**$43,136.16**	**$3,095.07**	**$37,140.84**
$ Change from Current			**$862.03**	**$10,344.36**	**($1,109.52)**	**($13,314.24)**	**($1,609.13)**	**($19,309.56)**
% Change from Current			**18.32%**		**-23.59%**		**-34.21%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		HAP PPO $0		HAP PPO $500	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**HAP PPO / Aetna PPO**		**HAP PPO / Aetna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$0**	**$3,000**	**$500**	**$3,000**
Family	$500	$1,000	$500	$1,000	**$0**	**$6,000**	**$1,000**	**$6,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**50%**	**100%**	**50%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$4,000**	**$20,000**	**$2,500**	**$20,000**
Family	$13,200	$26,400	$13,200	$26,400	**$8,000**	**$40,000**	**$5,000**	**$40,000**
In-Network Employee Copay:								
Office Visit	$20		$20		$20		$20	
Virtual Care Visit	$20		$20		**$0****		**$0****	
Specialist Visit	$40		$40		$40		$40	
Urgent Care	$60		$60		**$65**		**$65**	
Emergency Room	$150		$150		**$200**		**$200**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**0% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$10		$10		**$5 / $15**		**$5 / $15**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$30 / $60**		**$30 / $60**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max / 50% $500 Max**		**20% $200 Max / 50% $500 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PPO Platinum A0		PPO Platinum A050	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$5,261.39**	**$63,136.68**	**$5,054.02**	**$60,648.24**
$ Change from Current			**$862.03**	**$10,344.36**	**$557.19**	**$6,686.28**	**$349.82**	**$4,197.84**
% Change from Current			**18.32%**		**11.84%**		**7.44%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80%		Renewal Plan - BCBSM PPO $250 80%		HAP PPO $1000		HAP PPO $1200	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	BCBS National PPO		BCBS National PPO		HAP PPO / Aetna PPO		HAP PPO / Aetna PPO	
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$250	$500	$250	$500	$1,000	$2,000	$1,200	$3,000
Family	$500	$1,000	$500	$1,000	$2,000	$4,000	$2,400	$6,000
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	50%	100%	50%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$6,600	$13,200	$6,600	$13,200	$8,200	$20,000	$8,200	$20,000
Family	$13,200	$26,400	$13,200	$26,400	$16,400	$40,000	$16,400	$40,000
In-Network Employee Copay:								
Office Visit	$20		$20		$35		$35	
Virtual Care Visit	$20		$20		$0**		$0**	
Specialist Visit	$40		$40		$60		$60	
Urgent Care	$60		$60		$65		$65	
Emergency Room	$150		$150		$300		$300	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		0% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	Custom Select		Custom Select		N/A		N/A	
Tier 1 / 1A: Generic	$10		$10		$5 / $25		$5 / $30	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max / 50% $500 Max		20% $200 Max / 50% $500 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PPO Gold B1		PPO Gold B12	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,914.20**	**$46,970.40**	**$4,168.79**	**$50,025.48**
$ Change from Current			**$862.03**	**$10,344.36**	**($790.00)**	**($9,480.00)**	**($535.41)**	**($6,424.92)**
% Change from Current			**18.32%**		**-16.79%**		**-11.38%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80%		Renewal Plan - BCBSM PPO $250 80%		Priority Health PPO 250 100%		Priority Health PPO 475 90%	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	BCBS National PPO		BCBS National PPO		Priority Health PPO / Cigna PPO		Priority Health PPO / Cigna PPO	
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$250	$500	$250	$500	$250	$500	$475	$950
Family	$500	$1,000	$500	$1,000	$500	$1,000	$950	$1,900
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	70%	90%	70%
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$6,600	$13,200	$6,600	$13,200	$5,000	$10,000	$2,250	$4,500
Family	$13,200	$26,400	$13,200	$26,400	$10,000	$20,000	$4,500	$9,000
In-Network Employee Copay:								
Office Visit	$20		$20		$15		$15	
Virtual Care Visit	$20		$20		$10		$10	
Specialist Visit	$40		$40		$35		$45	
Urgent Care	$60		$60		$75		$75	
Emergency Room	$150		$150		$250 after Deductible		$300 after Deductible	
Hospital Admission	20% after Deductible		20% after Deductible		0% after Deductible		10% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	Custom Select		Custom Select		Optimized		Optimized	
Tier 1 / 1A: Generic	$10		$10		$5 / $10		$5 / $15	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		20% $200 Max / 20% $300 Max		20% $200 Max / 20% $300 Max	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PriorityPPO Platinum P251		PriorityPPO Platinum P47	
Monthly / Annual Premium	$4,704.20	$56,450.40	$5,566.23	$66,794.76	$5,253.72	$63,044.64	$5,076.66	$60,919.92
$ Change from Current			$862.03	$10,344.36	$549.52	$6,594.24	$372.46	$4,469.52
% Change from Current			18.32%		11.68%		7.92%	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		Priority Health PPO 500		Priority Health PPO 1200	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**Priority Health PPO / Cigna PPO**		**Priority Health PPO / Cigna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,200**	**$2,400**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,400**	**$4,800**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	**100%**	**70%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,500**	**$11,000**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$11,000**	**$22,000**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$9,600**	**$19,200**	**$9,100**	**$18,200**
Family	$13,200	$26,400	$13,200	$26,400	**$19,200**	**$38,400**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$10**		**$10**	
Specialist Visit	$40		$40		**$60**		**$70**	
Urgent Care	$60		$60		**$85**		**$85**	
Emergency Room	$150		$150		**$350 after Deductible**		**$350 after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		**0% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Optimized**		**Optimized**	
Tier 1 / 1A: Generic	$10		$10		**$5 / $35**		**$5 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $95**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $250 Max / 20% $450 Max**		**20% $250 Max / 20% $450 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PriorityPPO Gold G50		PriorityPPO Gold G121	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,313.79**	**$51,765.48**	**$4,432.20**	**$53,186.40**
$ Change from Current			**$862.03**	**$10,344.36**	**($390.41)**	**($4,684.92)**	**($272.00)**	**($3,264.00)**
% Change from Current			**18.32%**		**-8.30%**		**-5.78%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		Priority Health POS 250 100%		Priority Health POS 475 90%	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**Priority Health POS / Cigna PPO**		**Priority Health POS / Cigna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	$250	$500	**$475**	**$950**
Family	$500	$1,000	$500	$1,000	$500	$1,000	**$950**	**$1,900**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	**100%**	**70%**	**90%**	**70%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$5,000**	**$10,000**	**$2,250**	**$4,500**
Family	$13,200	$26,400	$13,200	$26,400	**$10,000**	**$20,000**	**$4,500**	**$9,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$15**	
Virtual Care Visit	$20		$20		**$10**		**$10**	
Specialist Visit	$40		$40		**$35**		**$45**	
Urgent Care	$60		$60		**$75**		**$75**	
Emergency Room	$150		$150		**$250 after Deductible**		**$300 after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**10% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Optimized**		**Optimized**	
Tier 1 / 1A: Generic	$10		$10		**$5** / $10		**$5** / **$15**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / $80		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $200 Max / 20% $300 Max**		**20% $200 Max / 20% $300 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PriorityPOS Platinum P251		PriorityPOS Platinum P47	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,436.48**	**$53,237.76**	**$4,311.75**	**$51,741.00**
$ Change from Current			**$862.03**	**$10,344.36**	**($267.72)**	**($3,212.64)**	**($392.45)**	**($4,709.40)**
% Change from Current			**18.32%**		**-5.69%**		**-8.34%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80% (Current Billed Ages)		Renewal Plan - BCBSM PPO $250 80% (Renewal Billed Ages)		Priority Health POS 500		Priority Health POS 1200	
Provider Network:								
In State / Out of State Residents	**BCBS National PPO**		**BCBS National PPO**		**Priority Health POS / Cigna PPO**		**Priority Health POS / Cigna PPO**	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,200**	**$2,400**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,400**	**$4,800**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	60%	**100%**	**70%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**$5,500**	**$11,000**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**$11,000**	**$22,000**	**N/A**	**N/A**
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$6,600	$13,200	$6,600	$13,200	**$9,600**	**$19,200**	**$9,100**	**$18,200**
Family	$13,200	$26,400	$13,200	$26,400	**$19,200**	**$38,400**	**$18,200**	**$36,400**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$30**	
Virtual Care Visit	$20		$20		**$10**		**$10**	
Specialist Visit	$40		$40		**$60**		**$70**	
Urgent Care	$60		$60		**$85**		**$85**	
Emergency Room	$150		$150		**$350 after Deductible**		**$350 after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		**0% after Deductible**	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**Optimized**		**Optimized**	
Tier 1 / 1A: Generic	$10		$10		**$5 / $35**		**$5 / $30**	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		**$80 / $95**		$40 / $80	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**20% $250 Max / 20% $450 Max**		**20% $250 Max / 20% $450 Max**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		PriorityPOS Gold G50		PriorityPOS Gold G121	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$3,707.00**	**$44,484.00**	**$3,792.21**	**$45,506.52**
$ Change from Current			**$862.03**	**$10,344.36**	**($997.20)**	**($11,966.40)**	**($911.99)**	**($10,943.88)**
% Change from Current			**18.32%**		**-21.20%**		**-19.39%**	

Medical Policy # 007005509-0000 *Renewal Date: 11/1/2026*	Current Plan BCBSM PPO $250 80%		Renewal Plan - BCBSM PPO $250 80%		United Healthcare EN-72		United Healthcare EN-74	
Provider Network:	(Current Billed Ages)		(Renewal Billed Ages)					
In State / Out of State Residents	BCBS National PPO		BCBS National PPO		United Healthcare ChoicePlus		United Healthcare ChoicePlus	
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$250	$500	$250	$500	**$0**	**$5,000**	**$500**	**$5,000**
Family	$500	$1,000	$500	$1,000	**$0**	**$10,000**	**$1,000**	**$10,000**
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	80%	**50%**	80%	**50%**
Coinsurance Max - Single	$1,000	$2,000	$1,000	$2,000	**N/A**	**N/A**	**N/A**	**N/A**
Coinsurance Max - Family	$2,000	$4,000	$2,000	$4,000	**N/A**	**N/A**	**N/A**	**N/A**
EE True Out of Pocket Max:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$6,600	$13,200	$6,600	$13,200	**$3,000**	**$10,000**	**$2,000**	**$10,000**
Family	$13,200	$26,400	$13,200	$26,400	**$6,000**	**$20,000**	**$4,000**	**$20,000**
In-Network Employee Copay:								
Office Visit	$20		$20		**$30**		**$0**	
Virtual Care Visit	$20		$20		**Covered 100%**		**Covered 100%**	
Specialist Visit	$40		$40		**$60**		**$100**	
Urgent Care	$60		$60		**$50**		**$50**	
Emergency Room	$150		$150		**$500 after Deductible**		**20% after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		20% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Prescription Formulary Type	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Tier 1 / 1A: Generic	$10		$10		$10		$10	
Tier 2 / 3: Pref. / Non-Pref. Brand	$40 / $80		$40 / $80		$40 / **$105**		$40 / **$105**	
Tier 4 / 5: Pref. / Non-Pref. Specialty	15% $150 Max / 25% $300 Max		15% $150 Max / 25% $300 Max		**$250 / $500**		**$250 / $500**	
Lifestyle Drugs (Excludes Weight Loss)	Excluded		Excluded		Excluded		Excluded	
Plan Provisions:								
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Dependent Age	End of Year Age 26		End of Year Age 26		**End of Month Age 26**		**End of Month Age 26**	
Pediatric Dental	Not Included		Not Included		Automatically Included		Automatically Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Carrier Plan Name Identifier	SB PPO Platinum		SB PPO Platinum		N/A		N/A	
Monthly / Annual Premium	**$4,704.20**	**$56,450.40**	**$5,566.23**	**$66,794.76**	**$4,835.13**	**$58,021.56**	**$4,848.23**	**$58,178.76**
$ Change from Current			**$862.03**	**$10,344.36**	**$130.93**	**$1,571.16**	**$144.03**	**$1,728.36**
% Change from Current			**18.32%**		**2.78%**		**3.06%**	

Dental Analysis

Dental Policy # *4554* *Renewal Date:* *11/1/2026*		Current Delta Dental			Renewal Delta Dental			Delta Dental - Option #1		
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Nonparticipating**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes			Yes	
Calendar Year Max Per Person			$1,500			$1,500			$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates			Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included			Not Included / Included	
Type I - Preventative Services:										
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	**4x**	**4x**	**4x**
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:										
Fillings		80%	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:										
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:										
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A			N/A	
Orthodontic Age Limit			N/A			N/A			N/A	
Plan Administration:										
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees		
Waiting Periods		None			None			None		
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26		
Hourly Requirement		30 Hours			30 Hours			30 Hours		
Headcounts / Rates:										
Single	**27**		**$53.99**			**$53.99**			**$55.29**	
EE & Spouse	**6**		**$99.34**			**$99.34**			**$101.73**	
EE & Child	**0**		**$99.34**			**$99.34**			**$101.73**	
EE & Children	**0**		**$166.46**			**$166.46**			**$170.47**	
Family	**4**		**$166.46**			**$166.46**			**$170.48**	
Total Enrolled	**37**									
Rate Guarantee Duration:						12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,785.12**		**$33,421.42**
$ Change from Current					**$0.00**		**$0.00**	**$65.51**		**$786.10**
% Change from Current						**0.00%**			**2.41%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*	Current Delta Dental			Renewal Delta Dental			Delta Dental - Option #2		
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Nonparticipating**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes			Yes	
Calendar Year Max Per Person		$1,500			$1,500			**$2,000**	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates			Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included			Not Included / Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings	80%	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A			N/A	
Orthodontic Age Limit		N/A			N/A			N/A	
Plan Administration:									
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees		
Waiting Periods	None			None			None		
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26		
Hourly Requirement	30 Hours			30 Hours			30 Hours		
Headcounts / Rates:									
Single **27**		**$53.99**			**$53.99**			**$55.39**	
EE & Spouse **6**		**$99.34**			**$99.34**			**$101.89**	
EE & Child **0**		**$99.34**			**$99.34**			**$101.89**	
EE & Children **0**		**$166.46**			**$166.46**			**$170.75**	
Family **4**		**$166.46**			**$166.46**			**$170.72**	
Total Enrolled **37**									
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027		
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,789.75**		**$33,477.00**
$ Change from Current				**$0.00**		**$0.00**	**$70.14**		**$841.68**
% Change from Current					**0.00%**			**2.58%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*	Current Delta Dental			Renewal Delta Dental			Delta Dental - Option #3		
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Nonparticipating**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes			Yes	
Calendar Year Max Per Person		$1,500			$1,500			**$2,000**	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates			Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included			Not Included / Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	**4x**	**4x**	**4x**
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings	80%	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A			N/A	
Orthodontic Age Limit		N/A			N/A			N/A	
Plan Administration:									
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees		
Waiting Periods	None			None			None		
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26		
Hourly Requirement	30 Hours			30 Hours			30 Hours		
Headcounts / Rates:									
Single **27**		**$53.99**			**$53.99**			**$56.72**	
EE & Spouse **6**		**$99.34**			**$99.34**			**$104.36**	
EE & Child **0**		**$99.34**			**$99.34**			**$104.36**	
EE & Children **0**		**$166.46**			**$166.46**			**$174.88**	
Family **4**		**$166.46**			**$166.46**			**$174.88**	
Total Enrolled **37**									
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027		
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,857.12**		**$34,285.44**
$ Change from Current				**$0.00**		**$0.00**	**$137.51**		**$1,650.12**
% Change from Current					**0.00%**			**5.06%**	

Dental Policy # 4554 *Renewal Date: 11/1/2026*	Current Delta Dental			Renewal Delta Dental			MetLife[2]	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	MetLife PDP Plus	**90th**
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		Not Included / Included	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-Greater of 50% or 10 EE's	
Waiting Periods	None			None			None	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement	30 Hours			30 Hours			30 Hours	
Headcounts / Rates:								
Single **27**		**$53.99**			**$53.99**		**$43.44**	
EE & Spouse **6**		**$99.34**			**$99.34**		**$82.75**	
EE & Child **0**		**$99.34**			**$99.34**		**$82.75**	
EE & Children **0**		**$166.46**			**$166.46**		**$141.50**	
Family **4**		**$166.46**			**$166.46**		**$141.50**	
Total Enrolled **37**								
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,235.38**	**$26,824.56**
$ Change from Current				**$0.00**		**$0.00**	**($484.23)**	**($5,810.76)**
% Change from Current					**0.00%**		**-17.81%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*	Current Delta Dental			Renewal Delta Dental			Kansas City Life	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Dental Health Alliance	90th
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Not Included	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		Included / Not Included	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory - 75% w/ Min. 10 EE's	
Waiting Periods	None			None			None	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Month Age 26	
Hourly Requirement	30 Hours			30 Hours			To End of Year Age 26	
Headcounts / Rates:								
Single **27**		**$53.99**			**$53.99**		**$48.53**	
EE & Spouse **6**		**$99.34**			**$99.34**		**$89.29**	
EE & Child **0**		**$99.34**			**$99.34**		**$89.29**	
EE & Children **0**		**$166.46**			**$166.46**		**$149.62**	
Family **4**		**$166.46**			**$166.46**		**$149.62**	
Total Enrolled **37**							*Requires EHB on Medical*	
Rate Guarantee Duration:					12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,444.53**	**$29,334.36**
$ Change from Current				**$0.00**		**$0.00**	**($275.08)**	**($3,300.96)**
% Change from Current					**0.00%**		**-10.11%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*		Current Delta Dental			Renewal Delta Dental			Guardian *(Sold w/ Current Lines)*	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	**90th**
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included** / Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80% / **50%**	80% / **50%**
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods		None			None			None	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement		30 Hours			30 Hours			30 Hours	
Headcounts / Rates:									
Single	**27**		**$53.99**			**$53.99**		**$50.31**	
EE & Spouse	**6**		**$99.34**			**$99.34**		**$99.71**	
EE & Child	**0**		**$99.34**			**$99.34**		**$99.71**	
EE & Children	**0**		**$166.46**			**$166.46**		**$180.47**	
Family	**4**		**$166.46**			**$166.46**		**$180.47**	
Total Enrolled	**37**								
Rate Guarantee Duration:						12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,678.51**	**$32,142.12**
$ Change from Current					**$0.00**		**$0.00**	**($41.10)**	**$32,142.12**
% Change from Current						**0.00%**		**-1.51%**	

Dental Policy # 4554 *Renewal Date: 11/1/2026*	Current Delta Dental			Renewal Delta Dental			UNUM	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DenteMax	**90th**
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		**Not Included**	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		**Included / Not Included**	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods	None			None			None	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement	30 Hours			30 Hours			30 Hours	
Headcounts / Rates:								
Single **27**		**$53.99**			**$53.99**		**$54.71**	
EE & Spouse **6**		**$99.34**			**$99.34**		**$100.67**	
EE & Child **0**		**$99.34**			**$99.34**		**$100.67**	
EE & Children **0**		**$166.46**			**$166.46**		**$168.70**	
Family **4**		**$166.46**			**$166.46**		**$168.70**	
Total Enrolled **37**							***Requires EHB on Medical***	
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,755.99**	**$33,071.88**
$ Change from Current				**$0.00**		**$0.00**	**$36.38**	**$436.56**
% Change from Current					**0.00%**		**1.34%**	

Dental Policy # 4554 *Renewal Date: 11/1/2026*	Current Delta Dental			Renewal Delta Dental			MetLife[2] - Option #1	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	MetLife PDP Plus	**90th**
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		**$2,000**	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		Not Included / Included	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory-Greater of 50% or 10 EE's	
Waiting Periods	None			None			None	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement	30 Hours			30 Hours			30 Hours	
Headcounts / Rates:								
Single **27**		**$53.99**			**$53.99**		**$45.98**	
EE & Spouse **6**		**$99.34**			**$99.34**		**$87.49**	
EE & Child **0**		**$99.34**			**$99.34**		**$87.49**	
EE & Children **0**		**$166.46**			**$166.46**		**$148.60**	
Family **4**		**$166.46**			**$166.46**		**$148.60**	
Total Enrolled **37**								
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,360.80**	**$28,329.60**
$ Change from Current				**$0.00**		**$0.00**	**($358.81)**	**($4,305.72)**
% Change from Current					**0.00%**		**-13.19%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*		Current Delta Dental			Renewal Delta Dental			Kansas City Life - Option #1	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Dental Health Alliance	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		**$2,000**	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		**Not Included**	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included / Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contributory - 75% w/ Min. 10 EE's	
Waiting Periods		None			None			None	
Dependent Age		To End of Year Age 26			To End of Year Age 26			**To End of Month Age 26**	
Hourly Requirement		30 Hours			30 Hours			To End of Year Age 26	
Headcounts / Rates:									
Single	**27**		**$53.99**			**$53.99**		**$52.84**	
EE & Spouse	**6**		**$99.34**			**$99.34**		**$97.23**	
EE & Child	**0**		**$99.34**			**$99.34**		**$97.23**	
EE & Children	**0**		**$166.46**			**$166.46**		**$162.92**	
Family	**4**		**$166.46**			**$166.46**		**$162.99**	
Total Enrolled	**37**							***Requires EHB on Medical***	
Rate Guarantee Duration:						12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,662.03**	**$31,944.34**
$ Change from Current					**$0.00**		**$0.00**	**($57.58)**	**($690.98)**
% Change from Current						**0.00%**		**-2.12%**	

Dental Policy # 4554 *Renewal Date: 11/1/2026*		Current Delta Dental			Renewal Delta Dental			UNUM - Option #1	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DenteMax	**90th**
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		**$2,000**	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		**Not Included**	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included / Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods		None			None			None	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement		30 Hours			30 Hours			30 Hours	
Headcounts / Rates:									
Single	**27**		**$53.99**			**$53.99**		**$54.77**	
EE & Spouse	**6**		**$99.34**			**$99.34**		**$105.70**	
EE & Child	**0**		**$99.34**			**$99.34**		**$105.70**	
EE & Children	**0**		**$166.46**			**$166.46**		**$177.12**	
Family	**4**		**$166.46**			**$166.46**		**$177.12**	
Total Enrolled	**37**							***Requires EHB on Medical***	
Rate Guarantee Duration:						12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,821.47**	**$33,857.64**
$ Change from Current					**$0.00**		**$0.00**	**$101.86**	**$1,222.32**
% Change from Current						**0.00%**		**3.75%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*		Current Delta Dental			Renewal Delta Dental			Guardian - Option #1 *(Sold w/ Current Lines)*	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	**90th**
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		**$2,000**	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included** / Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80% / **50%**	80% / **50%**
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods		None			None			None	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement		30 Hours			30 Hours			30 Hours	
Headcounts / Rates:									
Single	**27**		**$53.99**			**$53.99**		**$54.24**	
EE & Spouse	**6**		**$99.34**			**$99.34**		**$107.21**	
EE & Child	**0**		**$99.34**			**$99.34**		**$107.21**	
EE & Children	**0**		**$166.46**			**$166.46**		**$192.70**	
Family	**4**		**$166.46**			**$166.46**		**$192.70**	
Total Enrolled	**37**								
Rate Guarantee Duration:						12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,878.54**	**$34,542.48**
$ Change from Current					**$0.00**		**$0.00**	**$158.93**	**$34,542.48**
% Change from Current						**0.00%**		**5.84%**	

Dental Policy # *4554* *Renewal Date:* *11/1/2026*		Current Delta Dental			Renewal Delta Dental			Guardian - Option #2 *(Sold w/ Current Lines)*	
Plan Provisions:		**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR		Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	**90th**
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative			Yes			Yes		Yes	
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage			Not Included / Included			Not Included / Included		**Included** / Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	**4x**	**4x**
Exams / Flouride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia		80%	80%	80%	80%	80%	80%	80% / **50%**	80% / **50%**
Periodontics / Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants		50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max			N/A			N/A		N/A	
Orthodontic Age Limit			N/A			N/A		N/A	
Plan Administration:									
Participation Requirement		Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods		None			None			None	
Dependent Age		To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement		30 Hours			30 Hours			30 Hours	
Headcounts / Rates:									
Single	**27**		**$53.99**			**$53.99**		**$51.64**	
EE & Spouse	**6**		**$99.34**			**$99.34**		**$102.37**	
EE & Child	**0**		**$99.34**			**$99.34**		**$102.37**	
EE & Children	**0**		**$166.46**			**$166.46**		**$185.50**	
Family	**4**		**$166.46**			**$166.46**		**$185.50**	
Total Enrolled	**37**								
Rate Guarantee Duration:						12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027	
Monthly / Annual Premium		**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,750.50**	**$33,006.00**
$ Change from Current					**$0.00**		**$0.00**	**$30.89**	**$33,006.00**
% Change from Current						**0.00%**		**1.14%**	

Dental Policy # 4554 *Renewal Date: 11/1/2026*	Current Delta Dental			Renewal Delta Dental			Guardian - Option #3 *(Sold w/ Current Lines)*	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	**90th**
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Deductible Waived for Preventative		Yes			Yes		Yes	
Calendar Year Max Per Person		$1,500			$1,500		**$2,000**	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover / Preventative Advantage		Not Included / Included			Not Included / Included		**Included** / Included	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	**4x**	**4x**
Exams / Flouride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery / Anesthesia	80%	80%	80%	80%	80%	80%	80% / **50%**	80% / **50%**
Periodontics / Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures / Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontic Lifetime Max		N/A			N/A		N/A	
Orthodontic Age Limit		N/A			N/A		N/A	
Plan Administration:								
Participation Requirement	Contributory-75% of All Eligible Employees			Contributory-75% of All Eligible Employees			Contribuotry - 94% of EE's Enrolled	
Waiting Periods	None			None			None	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Hourly Requirement	30 Hours			30 Hours			30 Hours	
Headcounts / Rates:								
Single **27**		**$53.99**			**$53.99**		**$54.15**	
EE & Spouse **6**		**$99.34**			**$99.34**		**$107.35**	
EE & Child **0**		**$99.34**			**$99.34**		**$107.35**	
EE & Children **0**		**$166.46**			**$166.46**		**$194.57**	
Family **4**		**$166.46**			**$166.46**		**$194.57**	
Total Enrolled **37**								
Rate Guarantee Duration:				12 Months - Expires 11/01/2027			12 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$2,719.61**		**$32,635.32**	**$2,719.61**		**$32,635.32**	**$2,884.43**	**$34,613.16**
$ Change from Current				**$0.00**		**$0.00**	**$164.82**	**$34,613.16**
% Change from Current					**0.00%**		**6.06%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan Blue Vision**		**Renewal Plan Blue Vision**		**UNUM**		**Delta Vision**	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	**$10**	Up to $45
Materials	$10		$10		**$25**		**$25**	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	**$200**	$38.25	$130	**$91**	$130	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$130	**$130**	$130	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		91% of EE's Enrolled		Min. 2 Enrolled - Sold w/ Delta Dental	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single **26**	**Age Banded**		**Age Banded**		**$4.87**		**$6.41**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$9.75**		**$12.84**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$10.61**		**$13.74**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$10.61**		**$13.74**	
Family **3**	**Age Banded**		**Age Banded**		**$16.70**		**$21.96**	
Total Enrolled **32**								
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**48 Months - Expires 11/01/2030**		12 Months - Expires 11/01/2027	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$207.69**	**$2,492.28**	**$272.86**	**$3,274.32**
$ Change from Current			**$6.28**	**$75.36**	**$67.75**	**$813.00**	**$132.92**	**$1,595.04**
% Change from Current			**4.49%**		**48.41%**		**94.98%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan Blue Vision**		**Renewal Plan Blue Vision**		**Kansas City Life**		**MetLife**	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $45**	$5	**Up to $45**
Materials	$10		$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$65**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$100**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	**$200**	$38.25	$130	**$70**	$130	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$130	**$105**	$130	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**		**VSP Choice + MetLife Vision PPO**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		**To End of Month Age 26**		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		40% of EE's with Min. 2 Enrolled		Greater of 25% of EE's or 10 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single **26**	**Age Banded**		**Age Banded**		**$7.18**		**$8.42**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$14.36**		**$16.88**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$15.37**		**$14.29**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$15.37**		**$14.29**	
Family **3**	**Age Banded**		**Age Banded**		**$24.57**		**$23.56**	
Total Enrolled **32**								
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$305.49**	**$3,665.88**	**$335.06**	**$4,020.72**
$ Change from Current			**$6.28**	**$75.36**	**$165.55**	**$1,986.60**	**$195.12**	**$2,341.44**
% Change from Current			**4.49%**		**118.30%**		**139.43%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan** **Blue Vision**		**Renewal Plan** **Blue Vision**		**Guardian** *(Package Sale - Sold w/ Guardian Dental)*	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $39**
Materials	$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**	
Lenses / Contact Lenses	24		24		**12**	
Frames	24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$23**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$37**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$49**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$64**
Frames	$130	$38.25	**$200**	$38.25	$130	**$46**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	$130	$100
Plan Provisions:						
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**	
Contact Lenses in Lieu of Frames	No		No		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Voluntary - 91% of EE's Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours	
Headcounts / Rates:						
Single **26**	**Age Banded**		**Age Banded**		**$8.96**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$16.97**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$17.29**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$17.29**	
Family **3**	**Age Banded**		**Age Banded**		**$27.37**	
Total Enrolled **32**						
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$366.62**	**$4,399.44**
$ Change from Current			**$6.28**	**$75.36**	**$226.68**	**$2,720.16**
% Change from Current			**4.49%**		**161.98%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan Blue Vision**		**Renewal Plan Blue Vision**		**UNUM - Option #1**		**Kansas City Life - Option #1**	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	**$10**	**Up to $45**
Materials	$10		$10		**$25**		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	**$200**	$38.25	**$150**	**$105**	**$150**	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	**$150**	**$150**	**$150**	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		**To End of Month Age 26**	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		91% of EE's Enrolled		40% of EE's with Min. 2 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single **26**	**Age Banded**		**Age Banded**		**$5.02**		**$7.58**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$10.02**		**$15.16**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$10.87**		**$16.22**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$10.87**		**$16.22**	
Family **3**	**Age Banded**		**Age Banded**		**$17.12**		**$25.93**	
Total Enrolled **32**								
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**48 Months - Expires 11/01/2030**		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$213.64**	**$2,563.68**	**$322.47**	**$3,869.64**
$ Change from Current			**$6.28**	**$75.36**	**$73.70**	**$884.40**	**$182.53**	**$2,190.36**
% Change from Current			**4.49%**		**52.67%**		**130.43%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan Blue Vision**		**Renewal Plan Blue Vision**		**Delta Vision - Option #1**		**MetLife - Option #1**	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $45**	$5	**Up to $45**
Materials	$10		$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$65**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$100**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	**$200**	$38.25	**$150**	**$70**	**$150**	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	**Paid-in-Full[4]**	$210
Elective Contacts	$130	$100	$130	$100	**$150**	**$105**	**$150**	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**		**VSP Choice + MetLife Vision PPO**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Min. 2 Enrolled - Sold w/ Delta Dental		Greater of 25% of EE's or 10 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single **26**	**Age Banded**		**Age Banded**		**$7.84**		**$8.78**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$15.66**		**$17.60**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$16.76**		**$14.90**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$16.76**		**$14.90**	
Family **3**	**Age Banded**		**Age Banded**		**$26.78**		**$24.58**	
Total Enrolled **32**								
Rate Guarantee Duration			12 Months - Expires 11/01/2027		12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$333.36**	**$4,000.32**	**$349.42**	**$4,193.04**
$ Change from Current			**$6.28**	**$75.36**	**$193.42**	**$2,321.04**	**$209.48**	**$2,513.76**
% Change from Current			**4.49%**		**138.22%**		**149.69%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan** **Blue Vision**		**Renewal Plan** **Blue Vision**		**Guardian - Option #1** *(Package Sale - Sold w/ Guardian Dental)*	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $39**
Materials	$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**	
Lenses / Contact Lenses	24		24		**12**	
Frames	24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$23**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$37**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$49**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$64**
Frames	$130	$38.25	**$200**	$38.25	**$150**	**$46**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	**$150**	$100
Plan Provisions:						
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**	
Contact Lenses in Lieu of Frames	No		No		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Voluntary - 91% of EE's Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours	
Headcounts / Rates:						
Single **26**	**Age Banded**		**Age Banded**		**$9.63**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$18.23**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$18.58**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$18.58**	
Family **3**	**Age Banded**		**Age Banded**		**$29.40**	
Total Enrolled **32**						
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$393.97**	**$4,727.64**
$ Change from Current			**$6.28**	**$75.36**	**$254.03**	**$3,048.36**
% Change from Current			**4.49%**		**181.53%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan Blue Vision**		**Renewal Plan Blue Vision**		**UNUM - Option #2**		**MetLife - Option #2**	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	$5	**Up to $45**
Materials	$10		$10		**$25**		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**		**12**	
Lenses / Contact Lenses	24		24		**12**		**12**	
Frames	24		24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$30**	Paid-in-Full[4]	**$30**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$50**	Paid-in-Full[4]	**$50**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$65**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$70**	Paid-in-Full[4]	**$100**
Frames	$130	$38.25	**$200**	$38.25	**$200**	**$140**	**$200**	**$70**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	**$200**	**$200**	**$200**	**$105**
Plan Provisions:								
Network	**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice + MetLife Vision PPO**	
Contact Lenses in Lieu of Frames	No		No		**Yes**		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		91% of EE's Enrolled		Greater of 25% of EE's or 10 Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours		30 Hours	
Headcounts / Rates:								
Single **26**	**Age Banded**		**Age Banded**		**$6.39**		**$9.64**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$12.79**		**$19.33**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$13.76**		**$16.36**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$13.76**		**$16.36**	
Family **3**	**Age Banded**		**Age Banded**		**$21.69**		**$26.98**	
Total Enrolled **32**								
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**48 Months - Expires 11/01/2030**		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$271.52**	**$3,258.24**	**$383.63**	**$4,603.56**
$ Change from Current			**$6.28**	**$75.36**	**$131.58**	**$1,578.96**	**$243.69**	**$2,924.28**
% Change from Current			**4.49%**		**94.03%**		**174.14%**	

Vision Policy # **See Medical** ***Renewal Date:*** **11/1/2026**	**Current Plan** **Blue Vision**		**Renewal Plan** **Blue Vision**		**Guardian - Option #2** *(Package Sale - Sold w/ Guardian Dental)*	
Plan Co-Payments:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations	$5	Up to $34	$5	Up to $34	**$10**	**Up to $39**
Materials	$10		$10		$10	
Frequency (# of Months):	***Once Every:***		***Once Every:***		***Once Every:***	
Examinations	24		24		**12**	
Lenses / Contact Lenses	24		24		**12**	
Frames	24		24		24	
Plan Allowances:	***Up to:***		***Up to:***		***Up to:***	
Single Vision Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$23**
Bifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$37**
Trifocal Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$49**
Lenticular Lenses	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	Pre-Determined Amount	Paid-in-Full[4]	**$64**
Frames	$130	$38.25	**$200**	$38.25	**$200**	**$46**
Medically Necessary Contacts	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts	$130	$100	$130	$100	**$200**	$100
Plan Provisions:						
Network	**VSP Choice**		**VSP Choice**		**VSP Choice**	
Contact Lenses in Lieu of Frames	No		No		**Yes**	
Dependent Age	To End of Year Age 26		To End of Year Age 26		End of Year Age 26	
Participation Requirement	Sold with BCBSM Medical		Sold with BCBSM Medical		Voluntary - 91% of EE's Enrolled	
Hourly Requirement	30 Hours		30 Hours		30 Hours	
Headcounts / Rates:						
Single **26**	**Age Banded**		**Age Banded**		**$11.11**	
EE & Spouse **1**	**Age Banded**		**Age Banded**		**$21.02**	
EE & Child **1**	**Age Banded**		**Age Banded**		**$21.42**	
EE & Children **1**	**Age Banded**		**Age Banded**		**$21.42**	
Family **3**	**Age Banded**		**Age Banded**		**$33.92**	
Total Enrolled **32**						
Rate Guarantee Duration			12 Months - Expires 11/01/2027		**24 Months - Expires 11/01/2028**	
Monthly / Annual Premium	**$139.94**	**$1,679.28**	**$146.22**	**$1,754.64**	**$454.48**	**$5,453.76**
$ Change from Current			**$6.28**	**$75.36**	**$314.54**	**$3,774.48**
% Change from Current			**4.49%**		**224.77%**	