Insurance Deductions -- With Wellness

MEDICAL (DOH)

Group # B17626	2025-2026 7/1/25-6/30/26 Premium	Monthly Premium (Employer) 80%	(Employee) 20%	Employee Cost Per Pay Check	diff per pay w/ renewal
HMO Blue Advantage (Basic Plan) - *eligible DOH - n/c if DOH after 15th of the mo for that mo*					
Employee	$835.87	$668.71	$167.16	$83.58	*$6.94*
Employee + Spouse	$1,682.50	$1,346.00	$336.50	$168.25	*$13.98*
Employee + Children	$1,614.63	$1,291.71	$322.92	$161.46	*$13.41*
Family	$2,498.09	$1,998.47	$499.62	$249.81	*$20.75*
Drug Card	*$10/$40/$60*				

Group # P75211					
PPO		(Employer) 75%	(Employee) 25%	Employee Cost Per Pay Check	
Employee	$998.89	$749.17	$249.72	$124.86	*$10.37*
Employee + Spouse	$2,010.69	$1,508.03	$502.66	$251.33	*$20.87*
Employee + Children	$1,929.54	$1,447.16	$482.38	$241.19	*$20.03*
Family	$2,985.32	$2,239.00	$746.32	$373.16	*$30.99*
Drug Card	*$10/$40/$60*				

Group # P17626 (EFFECTIVE 1/1/2025)					
HDHP / HSA		(Employer) 75%	(Employee) 25%	Employee Cost Per Pay Check	
Employee	$897.83	$673.37	$224.46	$112.23	*$9.32*
Employee + Spouse	$1,807.24	$1,355.44	$451.80	$225.90	*$18.76*
Employee + Children	$1,734.29	$1,300.73	$433.56	$216.78	*$18.00*
Family	$2,683.22	$2,012.42	$670.80	$335.40	*$27.86*
Seeding $1000 EE / $2000 EE+SP & EE+CH & Family					

DENTAL

Group # 10817 Delta Dental	2024-2025 Premium	Monthly Cost (Employer) 80%	(Employee) 20%	Employee Cost Per Pay Check	
PPO - Premier - *eligible DOH*					
Employee	$42.90	$34.32	$8.58	$4.29	*$0.00*
Employee + 1	$83.37	$66.71	$16.66	$8.33	*$0.00*
Employee + 2 or more	$133.69	$106.95	$26.74	$13.37	*$0.00*

VISION

Group # 1023236 BC/BS	2024-2025 Premium			Employee Cost Per Pay Check	
Eligible 1st of month following DOH					
Employee	$7.60			$3.80	*$0.00*
Employee + Spouse	$14.44			$7.22	*$0.00*
Employee + Children	$15.20			$7.60	*$0.00*
Family	$22.35			$11.18	*$0.00*