COBRA PLAN COMPARISON

2026 TO 2027

	CDHP1		CDHP2		PPO*	
	2026	2027	2026	2027	2026	2027
MONTHLY PREMIUMS						
Employee	$990.65	$1,054.81	$1,024.94	$1,089.62	$1,047.85	$1,115.57
Employee + Child(ren)	$1,783.20	$1,900.87	$1,844.88	$1,963.52	$1,886.12	$2,012.45
Employee + Spouse	$2,179.47	$2,318.37	$2,254.85	$2,394.94	$2,305.27	$2,449.84
Family	$3,170.13	$3,362.13	$3,279.80	$3,473.51	$3,353.12	$3,554.30
ANNUAL DEDUCTIBLE (no changes)	**IN-NETWORK**					
Individual	$3,000		$2,000		$1,900	
Family	$6,000		$4,000		$3,800	
OUT-OF-POCKET MAXIMUM (no changes)	**IN-NETWORK**					
Individual	$5,000		$4,000		$5,000	
Family	$10,000		$8,000		$10,000	
COINSURANCE (no changes)	**IN-NETWORK**					
Preventive Care	Covered at 100%		Covered at 100%		Covered at 100%	
Office Visit	20% after deductible		20% after deductible		$35 copay	
Specialist Office Visit					$70 copay	
Urgent Care					$100 copay	
Emergency Room					$300 copay	
Inpatient Facility Services					$300 copay & 30% after ded.	
Outpatient Charges					30% after deductible	
PHARMACY (no changes)	**IN-NETWORK**					
Preventive Prescriptions	Covered at 100%		Covered at 100%		Covered at 100%	
Retail Tier 1 (generics)	20% after deductible		20% after deductible		$10 copay	
Retail Tier 2 (brand formulary)					$50 copay	
Retail Tier 3 (brand non-formulary)					$100 copay	
Retail Tier 4 (specialty)					10% to $200 copay	
Mail Order (90 day supply)					$20/$150/$300/10% to $400	

*The PPO is a closed plan and only available to those currently enrolled in the plan.

	Delta Dental		VSP Vision	
	2026	2027	2026	2027
MONTHLY PREMIUMS				
Employee	$42.12	$44.60	$6.40	$6.94
Employee + Child(ren)	$80.02	$84.74	$13.66	$14.83
Employee + Spouse	$84.23	$89.20	$12.75	$13.84
Family	$134.77	$142.73	$21.80	$23.66

COBRA premiums are the full cost of coverage plus a 2% administrative fee.

See the **website** for full plan information, including out-of-network benefits.