SLEOLA ADDENDUM

January - December 2026

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

Wes Moore, Governor
Aruna Miller, Lieutenant Governor
Helene Grady, Secretary
Marc L. Nicole, Deputy Secretary

# Guide to Your Health Benefits

Together, we are working toward a **healthier community**.

## What's New in 2026?

*Healthcare FSA max increased to $3,300.*

*Dependent Care FSA max increased to $7,500.*

*New Payroll Deduction Schedule.*

*Visit mymdbenefits.com for information on all our plans.*

*See page 3 for "What's New in 2026" details.*

Chesapeake Bay Retriever

*Medicare-eligible retirees and Medicare-eligible dependents call Via Benefits at 1-855-556-4419 to enroll or change Medicare Part D plans for 2026!*

State Law Enforcement Officers Labor Alliance (SLEOLA) employees have different medical plan options, prescription plan design and rates than other employees and retirees under the State Employee and Retiree Health and Welfare Benefits Program (the Program). This addendum provides information on the medical and prescription coverage available and the rates. For all other health insurance options including dental, flexible spending, life insurance, or accidental death & dismemberment insurance, refer to the 2026 Guide To Your Health Benefits available online at: **https://dbm.maryland.gov/benefits**.

SLEOLA employees are not eligible to participate in the Wellness Program.

If you are a SLEOLA participant and are promoted to Lieutenant or above, you must enroll in the non-SLEOLA medical and prescription coverage within 60 days of the promotion in order to have no lapse in your health coverage. Upon retirement, all SLEOLA employees who are eligible and choose to continue benefits are only eligible to enroll in the non-SLEOLA medical and prescription plans.

| SLEOLA (January 1, 2026 to December 31, 2026)<br>CareFirst | | | | | |
|---|---|---|---|---|---|
| **Benefit** | **PPO** | | **POS** | | **EPO** |
| TYPE OF SERVICE | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK |
| **Annual Deductible** | | | | | |
| Individual | None | $250 | None | $250 | None |
| Family | None | $500 | None | $500 | None |
| **YEARLY MAXIMUM OUT-OF-POCKET COSTS** | | | | | |
| **Coinsurance Out-of-Pocket** | | | | | |
| Individual | None | $3,000 | None | $3,000 | None |
| Family | None | $6,000 | None | $6,000 | None |
| **Copayment Out-of-Pocket** | | | | | |
| Individual | $1,000 | None | $1,000 | None | $1,000 |
| Family | $2,000 | None | $2,000 | None | $2,000 |
| **Total Medical Out-of-Pocket** | | | | | |
| Individual | $1,000 | $3,000 | $1,000 | $3,000 | $1,000 |
| Family | $2,000 | $6,000 | $2,000 | $6,000 | $2,000 |
| Lifetime Maximum | Unlimited | | | | |
| Network | National | | Regional | | National |
| **HOSPITAL - INPATIENT SERVICES (Preauthorization Required)*** | | | | | |
| Inpatient Care | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Hospitalization | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Acute Inpatient Rehabilitation for Stroke and Traumatic Brain Injury Patients when Medically Necessary | 100% of allowed benefit | Not Covered | 100% of allowed benefit | Not Covered | 100% of allowed benefit |
| Anesthesia | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Surgery | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Organ Transplant | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| **HOSPITAL - OUTPATIENT SERVICES (Preauthorization Required)*** | | | | | |
| Chemotherapy/Radiation | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Diagnostic Lab & X-Ray | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Outpatient Surgery | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Anesthesia | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| **THERAPIES (Preauthorization Required)** | | | | | |
| Benefit Therapies | $25 copay | 80% of allowed benefit after deductible | $25 copay | 80% of allowed benefit after deductible | $25 copay |
| Physical Therapy (PT) and Occupational Therapy (OT) | PT/OT services must be preauthorized after the 20th visit, based on medical necessity; 50 days per plan year combine for PT/OT/Speech Therapy. | | | | |
| Speech Therapy | Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits. | | | | |

# SLEOLA (January 1, 2026 to December 31, 2026)
# CareFirst

| Benefit | PPO | | POS | | EPO |
|---|---|---|---|---|---|
| TYPE OF SERVICE | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK |
| **COMMON AND PREVENTIVE SERVICES** | | | | | |
| Physician Office Visit - Primary Care | $15 copay | 80% of allowed benefit after deductible | $15 copay | 80% of allowed benefit after deductible | $15 copay |
| Physician Office Visit - Specialist | $25 copay | 80% of allowed benefit after deductible | $25 copay | 80% of allowed benefit after deductible | $25 copay |
| Physical Exams and Associated Lab (Adult and Child) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| | One exam per plan year for all members and their dependents age 3 and older. | | | | |
| Well Baby Care | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| | Birth - 36 months: 13 visits total | | | | |
| Routine Annual GYN Exam (including PAP test) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| Preventive Cancer Screenings<br>• US Preventive Services Task Force (Grade A)<br>• Mammography<br>• Colonoscopy<br>• Well woman exam | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Screening: one mammogram per plan year (35+) | | | | |
| Diagnostic Cancer Screenings | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | No age/frequency limitation on diagnostic mammogram | | | | |
| Hearing Examinations (1 exam every 3 years) | $15 copay (PCP) or $25 copay (Specialists) for exam | 80% of allowed benefit after deductible for exam | $15 copay (PCP) or $25 copay (Specialists) for exam | Not covered, except for hearing aids as mandated for minor children | $15 copay (PCP) or $25 copay (Specialists) for exam |
| Hearing Aids (1 hearing aid per ear every 3 years) | 100% of allowed benefit for Basic Model Hearing Aid | 100% of allowed benefit for Basic Model Hearing Aid | 100% of allowed benefit for Basic Model Hearing Aid | | 100% of allowed benefit for Basic Model Hearing Aid |
| | Includes Maryland mandated benefit for hearing aids for minor children (0-18) effective 1/1/02, including hearing aids per each impaired ear for minor children. | | | | |
| Immunizations | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Immunizations are only covered as recommended by the U.S. Preventive Services Task Force. The immunization benefit covers immunizations required for participation in school athletics and Lyme Disease immunizations when medically necessary. | | | | |
| Flu Shots | 100% of allowed benefit | Not Covered | 100% of allowed benefit | Not Covered | 100% of allowed benefit |
| STI Screening & Counseling (including HPV DNA and HIV) | 100% of allowed benefit | Not covered | 100% of allowed benefit | Not covered | 100% of allowed benefit |
| | Counseling and screening for sexually active women as mandated by PPACA. | | | | |
| Allergy Testing | $15 copay (PCP) or $25 copay (Specialists) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialists) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialists) |
| **EMERGENCY TREATMENT** | | | | | |
| Urgent Care Centers | $20 copay | 80% of allowed benefit after deductible | $20 copay | 80% of allowed benefit after deductible | $20 copay |
| Emergency Room (ER) Services - In and Out of Network | 100% of allowed benefit after $100 copay | 100% of allowed benefit after $100 copay | 100% of allowed benefit after $100 copay | 100% of allowed benefit after $100 copay | 100% of allowed benefit after $100 copay |
| | Copays are waived if admitted | | | | |
| | If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after $100 copay. | | | | |
| Observation - up to 23 hours and 59 minutes - presented via Emergency Department | 100% of allowed benefit after $100 copay | 80% of allowed benefit after deductible | 100% of allowed benefit after $100 copay | 80% of allowed benefit after deductible | 100% of allowed benefit after $100 copay |
| Observation - 24 hours or more - presented via Emergency Department | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Ambulance Services - Emergency Transport and Hospital Directed Transport between Approved Facilities | 100% of allowed benefit | 100% of allowed benefit | 100% of allowed benefit | 100% of allowed benefit | 100% of allowed benefit |
| Ambulance Services - Non-Emergency Transport | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| **MATERNITY BENEFITS** | | | | | |
| Maternity Benefits* | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Prenatal Care (Mandated) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Breastfeeding Support & Counseling (per birth) | 100% of allowed benefit | Not Covered | 100% of allowed benefit | Not Covered | 100% of allowed benefit |
| Breastfeeding Supplies (per birth) | 100% of allowed benefit | Not Covered | 100% of allowed benefit | Not Covered | 100% of allowed benefit |
| | Covers the cost of rental/purchase of certain breastfeeding pumps and pump supplies through the insurance carrier's durable medical equipment partner(s). | | | | |

# SLEOLA (January 1, 2026 to December 31, 2026)
# CareFirst

| Benefit | PPO | | POS | | EPO |
|---|---|---|---|---|---|
| TYPE OF SERVICE | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK |
| **OTHER SERVICES & SUPPLIES (Preauthorization Required)** | | | | | |
| Acupuncture Services for Chronic Pain Management | $20 copay | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Chiropractic Services | $20 copay | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Cardiac Rehabilitation** | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Dental Services | Not covered except as a result of accident or injury or as mandated by Maryland or federal law (if applicable). | | | | |
| Nutritional Counseling | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Durable Medical Equipment | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Must be medically necessary as determined by the attending physician. | | | | |
| Extended Care Facility | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered. | | | | |
| Family Planning & Fertility Testing | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy and vasectomy. | | | | |
| Contraception | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Includes IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, please refer to the Prescription Drug section of this addendum. | | | | |
| Contraceptive Counseling | 100% of allowed benefit | Not Covered | 100% of allowed benefit | Not Covered | 100% of allowed benefit |
| In Vitro Fertilization (IVF) & Artificial Insemination (AI) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | See carrier's evidence of coverage documents for details. Not covered following reversal of elective sterilization. | | | | |
| Hospice Care | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Home Health Care | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Home Health Care benefits are limited to 120 days per plan year. | | | | |
| Medical Supplies | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines. | | | | |
| Outpatient Prescription Drugs | Covered separately from Plan. See Prescription Drug Benefits Section. | | | | |
| Private Duty Nursing | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Whole Blood Charges | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| **MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES** | | | | | |
| Office Visit | $15 copay | 80% of allowed benefit after deductible | $15 copay | 80% of allowed benefit after deductible | $15 copay |
| Inpatient Hospital Care | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Partial Hospitalization Services | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Outpatient Services (including Intensive Outpatient Services) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Residential Crisis Services | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| | Habilitative Services, which include occupational therapy, physical therapy, speech therapy, and applied behavior analysis are covered for children under the age of 19 with congenital birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy. | | | | |

| SLEOLA (January 1, 2026 to December 31, 2026)<br>CareFirst | | | | | |
|---|---|---|---|---|---|
| **Benefit** | **PPO** | | **POS** | | **EPO** |
| TYPE OF SERVICE | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK |
| **VISION SERVICES (Adults 19 and older)** | | | | | |
| Vision – Medical (Services related to medical health of the eye) | $15 copay (PCP) or $25 copay (Specialist) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialist) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialist) |
| Vision – Routine (One per plan year) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Frames (One per plan year) | 100% of allowed benefit up to $45 per frame | 80% of allowed benefit after deductible up to $45 per frame | 100% of allowed benefit up to $45 per frame | 80% of allowed benefit after deductible up to $45 per frame | 100% of allowed benefit up to $45 per frame |
| Prescription Lenses | 100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181 | 80% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181 | 100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181 | 80% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181 | 100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181 |
| Contact Lenses (in lieu of frames & lenses) | 100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97 | 80% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97 | 100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97 | 80% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97 | 100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97 |
| **VISION SERVICES (Dependent children age 18 and under)** | | | | | |
| Vision – Medical (Services related to medical health of the eye) | $15 copay (PCP) or $25 copay (Specialist) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialist) | 80% of allowed benefit after deductible | $15 copay (PCP) or $25 copay (Specialist) |
| Vision – Routine (One per plan year) | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit | 80% of allowed benefit after deductible | 100% of allowed benefit |
| Frames (One per plan year) | 100% of allowed benefit up to $70 per frame | 80% of allowed benefit after deductible up to $70 per frame | 100% of allowed benefit up to $70 per frame | 80% of allowed benefit after deductible up to $70 per frame | 100% of allowed benefit up to $70 per frame |
| Basic Prescription Lenses | 100% priced at charges | | | | |
| Contact Lenses (in lieu of frames & lenses) | 100% of annual supply (2 refills per plan year) | 80% of annual supply (2 refills per plan year) | 100% of annual supply (2 refills per plan year) | 80% of annual supply (2 refills per plan year) | 100% of annual supply (2 refills per plan year) |

* Newborns' and Mothers' Health Protection Act Notice. See Guide To Your Health Benefits.

** Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medically necessary with a physician referral and patient history of a heart attack in past 12 months, Coronary Artery Bypass Graft (CABG) surgery, angioplasty, heart valve surgery, stable angina pectoris, congestive heart failure or heart and lung transplants. Inpatient care primarily for rehabilitation is not covered.

Medicare COB: If an employee or covered dependent's eligibility is due to ESRD, they must sign up for both Medicare Parts A & B as soon as they are eligible. If the Medicare eligible SLEOLA employee and/or their dependent(s) fail to enroll in Medicare, the Medicare eligible SLEOLA employee and/or dependent(s) will be responsible for any claim expenses that would have been paid under Medicare Parts A & B, had they enrolled in Medicare.

Non-Medicare COB: When the SLEOLA plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the SLEOLA plan.

| SLEOLA (January 1, 2026 to December 31, 2026)<br>PRESCRIPTION BENEFITS | | |
|---|---|---|
| ***Diabetic supplies now also available under prescription*** | | |
| **Copayments at Retail Pharmacies** | | |
| **Type of Drug** | **Prescription for 1-45 Days (1 copay)** | **Prescription for 46-90 Days (2 copays)** |
| Generic drug | $5 | $10 |
| Preferred brand name drug | $15 | $30 |
| Non-preferred brand name drug | $25 | $50 |
| **Copayments through Voluntary Mail Order Program** | | |
| **Type of Drug** | **Prescription for 1-45 Days (1 copay)** | **Prescription for 46-90 Days (2 copays)** |
| Generic | $5 | $10 |
| Preferred brand name | $15 | $20 |
| Non-preferred brand name | $25 | $20 |
| **Out-of-Pocket Maximum:** | | |
| Out-of-Pocket Maximum: | $700 | |
| | This means that when the total amount of copays you and your covered dependents pay during the plan year reaches $700, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year. | |

Refer to the 2026 Guide to your Health Benefits for detailed information on the Program's zero dollar copay generic drug program, the specialty drug management program, and other details related to the prescription drug benefits.

Employees and/or dependents with Medicare due to End Stage Renal Disease (ESRD) must enroll in Medicare Part D. See Benefits Guide pages 57-62.

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

**DEPARTMENT OF BUDGET & MANAGEMENT**
Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, MD 21201

# SLEOLA 2026 RATES

| CAREFIRST BC/BS HEALTH PLANS | | | | | | |
|---|---|---|---|---|---|---|
| Plan Type | Per Pay Period | | | Monthly Rates | | |
| | PPO | POS | EPO | PPO | POS | EPO |
| Individual | $85.30 | $60.11 | $58.04 | $184.82 | $130.24 | $125.76 |
| Individual + Child | $151.79 | $106.87 | $119.71 | $328.88 | $231.56 | $259.38 |
| Individual + Spouse | $151.79 | $106.87 | $119.71 | $328.88 | $231.56 | $259.38 |
| Individual + Family | $209.97 | $147.78 | $147.85 | $454.94 | $320.20 | $320.34 |

| PRESCRIPTION DRUG | | |
|---|---|---|
| Plan Type | Per Pay Period | Monthly Rates |
| Individual | $34.93 | $75.68 |
| Individual + Child | $46.41 | $100.56 |
| Individual + Spouse | $57.96 | $125.58 |
| Individual + Family | $69.85 | $151.34 |

| DENTAL PLANS | | | | |
|---|---|---|---|---|
| Plan Type | Delta Dental DHMO | | United Concordia DPPO | |
| | Per Pay Period | Monthly Rates | Per Pay Period | Monthly Rates |
| Individual | $4.21 | $9.12 | $7.26 | $15.74 |
| Individual + Child | $8.44 | $18.28 | $13.86 | $30.04 |
| Individual + Spouse | $7.35 | $15.92 | $14.51 | $31.44 |
| Individual + Family | $11.84 | $25.66 | $27.18 | $58.90 |

| ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PREMIUM RATES | | | | |
|---|---|---|---|---|
| Plan Coverage Level | Employee Only Bi-Weekly Rates | Employee + Family Bi-Weekly Rates | Employee Only Monthly Rates | Employee + Family Monthly Rates |
| $100,000 | $0.55 | $1.06 | $1.20 | $2.30 |
| $200,000 | $1.11 | $2.12 | $2.40 | $4.60 |
| $300,000 | $1.66 | $3.18 | $3.60 | $6.90 |

| TERM LIFE INSURANCE PREMIUM RATES | | | | | |
|---|---|---|---|---|---|
| Age of Employee/ Retiree | Bi-Weekly Employee Retiree Rates (per $1,000) | Monthly Employee Retiree Rates (per $1,000) | Age of Spouse | Bi-Weekly Spouse Rates (per $1,000) | Monthly Spouse Rates (per $1,000) |
| Under 30 | $0.01 | $0.03 | Under 30 | $0.04 | $0.09 |
| 30 to 34 | $0.02 | $0.04 | 30-34 | $0.05 | $0.10 |
| 35 to 39 | $0.02 | $0.05 | 35-39 | $0.06 | $0.12 |
| 40 to 44 | $0.04 | $0.08 | 40-44 | $0.08 | $0.18 |
| 45 to 49 | $0.06 | $0.13 | 45-49 | $0.13 | $0.28 |
| 50 to 54 | $0.09 | $0.20 | 50-54 | $0.19 | $0.42 |
| 55 to 59 | $0.17 | $0.37 | 55-59 | $0.30 | $0.65 |
| 60 to 64 | $0.24 | $0.52 | 60-64 | $0.46 | $1.00 |
| 65 to 69 | $0.36 | $0.77 | 65-69 | $0.67 | $1.45 |
| 70 to 74 | $0.64 | $1.38 | 70-74 | $1.05 | $2.28 |
| 75 to 79 | $0.95 | $2.06 | 75-79 | $1.05 | $2.28 |
| 80 and older | $0.95 | $2.06 | 80 and over | $1.05 | $2.28 |
| Dependent Child Coverage is $0.07 per $1,000 per bi-weekly pay period; $0.14 per $1,000 per month. | | | | | |

Rates may vary from what appears on your paystub due to rounding.



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