



CITY OF KOTZEBUE

RESOLUTION NO. 26-23

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF KOTZEBUE DIRECTING THE CITY MANAGER, HR LEAD, AND FINANCE DIRECTOR WORKING WITH THE CITY’S BROKER, THE ALERA GROUP, TO PROVIDE THE CITY OF KOTZEBUE (“CITY”) EMPLOYEES WITH AN AFFORDABLE AND COMPREHENSIVE HEALTH, DENTAL, VISION, PHARMACY, LIFE, AND SHORT-TERM DISABILITY PLANS FOR THE PERIOD JULY 1, 2026 THROUGH JUNE 30, 2027.

WHEREAS, health and dental care rates for the City employees continue to rise in Alaska and throughout the United States as has been the case for last several years and as set forth in the renewal paperwork “*City of Kotzebue 2026 Group Health Plan Renewal Evaluation*” for the period July 1, 2026 through June 30, 2027 from The Alera Group attached hereto as Exhibit “A” which provides various options for renewal for the FY2027 and the City Administration has reviewed and does recommend Renewal as the Basic Plan and Option 2 as the Upgrade Plan on page 2 of 15, Life/AD&D with Principal on page 8 of 15, and other coverages as necessary and/or optional.

WHEREAS, the City’s proposed health care insurance provider for FY2027, Premera, allows waivers of coverage on certain terms and conditions and the City desires to continue such an option.

WHEREAS, affordable and comprehensive health care insurance is an important benefit that the City wants to provide for its employees now and into the foreseeable future.

NOW, THEREFORE, BE IT RESOLVED, that the City Council of the City of Kotzebue approves the renewal recommendations from City Administration for the City of Kotzebue’s health, dental, vision, life, pharmacy, and short-term disability insurance coverages as set out above and in Exhibit “A” attached hereto for the period of July 1, 2026 through June 30, 2027.

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PASSED AND APPROVED by a duly constituted quorum of the City Council of the City of Kotzebue, Alaska, this 20th day of May 2026.

CITY OF KOTZEBUE

Saima Chase
Mayor

ATTEST:

[SEAL]

Donald Jones Jr
City Clerk

Attachments:

- **Exhibit A:** City of Kotzebue – 2026 Group Health Plan Renewal Evaluation [15 pages]

City of Kotzebue

2026 Group Health Plan Renewal Evaluation

Presented by: Leslie Shelton

Prepared by: Kristin Verone

Prepared: 05/2026

Exhibit A to Resolution 26-23 for RCCM May 20, 2026

Medical Comparison

Effective Date 7/1/2026

	Current	Renewal	Option 1	Option 2
	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross
	Preferred Choice Plus 4000	Preferred Choice Plus 4000	Preferred Choice Plus 1000	Preferred Choice Plus 2000
Network	Heritage	Heritage	Heritage	Heritage
HRA Employer Contribution	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.
Benefit Type	In-Network	In-Network	In-Network	In-Network
Deductible				
Individual / Family	\$4,000 / \$8,000 Embedded	\$4,000 / \$8,000 Embedded	\$1,000 / \$2,000 Embedded	\$2,000 / \$4,000 Embedded
Coinsurance	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Out-of-Pocket Maximum	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance
Individual / Family	\$6,000 / \$12,000 Embedded	\$6,000 / \$12,000 Embedded	\$4,500 / \$9,000 Embedded	\$4,500 / \$9,000 Embedded
Preventive Care	Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW
Office Visit				
Primary Care	\$30 copay DW	\$30 copay DW	\$25 copay DW	\$25 copay DW
Specialist	\$65 copay DW	\$65 copay DW	\$60 copay DW	\$65 copay DW
Urgent Care	\$40 copay DW	\$40 copay DW	\$40 copay DW	\$40 copay DW
Virtual Care Provider	Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW
Chiropractic / Acupuncture ⁽¹⁾	\$30 copay DW	\$30 copay DW	\$25 copay DW	\$25 copay DW
X-Ray & Lab	After deductible is met	After deductible is met	After deductible is met	After deductible is met
Diagnostic Lab	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Diagnostic X-Ray	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Complex - MRI, PET, CAT, CT	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Hospitalization	Afer deductible is met	Afer deductible is met	Afer deductible is met	Afer deductible is met
Inpatient Facility	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Outpatient Surgery	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Emergency Room	\$100 copay, then 20% Preferred	\$200 copay, then 20% Preferred	\$200 copay, then 20% Preferred	\$200 copay, then 20% Preferred
Prescription Drugs	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply
Formulary	Essentials E4	Essentials E4	Essentials E4	Essentials E4
Deductible	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.
Preferred Generic/Preferred Brand/Preferred Specialty/Non-Preferred all drugs	\$15 / \$30 / \$50 / 30%	\$15 / \$30 / \$60 / 30%	\$15 / \$30 / \$60 / 30%	\$15 / \$30 / \$60 / 30%
Vision	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW
Exam				
Hardware	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)
Non-Network**	Non-Network**	Non-Network**	Non-Network**	Non-Network**
Deductible (Individual / Family)	\$8,000 / \$16,000 Embedded	\$8,000 / \$16,000 Embedded	\$2,000 / \$4,000 Embedded	\$4,000 / \$8,000 Embedded
Out-of-Pocket Maximum (Individual / Family)	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded
Coinsurance	60%	60%	60%	60%
Rates	rollment*	Current	Option 1	Option 2
Employee Only (EE)	23	\$975.54	\$1,177.49	\$1,138.42
EE & Spouse	2	\$2,194.97	\$2,649.36	\$2,561.44
EE & Child(ren)	9	\$1,707.18	\$2,060.59	\$1,992.21
EE & Spouse & Child(ren)	1	\$2,896.62	\$3,532.49	\$3,415.26
Total	35			
Total Premiums				
Total Monthly	\$45,089	\$49,405	\$54,459	\$52,652
Total Annual	\$541,063	\$592,861	\$653,505	\$631,820
Annual % Change		9.57%	20.78%	16.77%
Annual \$ Change		\$51,798	\$112,442	\$90,757

DW = Deductible Waived

*Enrollment is based on Premera 2026 renewal. Rates are subject to change based on final enrollment.

**Additional Non-Network benefits may be available. More information is available if requested.

1. Visits have limits.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment and/or rates provided herein are subject to change for financial, contractual or other purposes only.

Exhibit A to Resolution 26-23 or PCCM May 20, 2026

Medical Comparison

Effective Date 7/1/2026

	Current	Renewal	Option 3	Option 4
	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross
	Preferred Choice Plus 4000	Preferred Choice Plus 4000	Preferred Choice Plus 3000	Preferred Choice HSA AGG 2000 Essentials
Network	Heritage	Heritage	Heritage	Heritage
HRA Employer Contribution	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.
Benefit Type	In-Network	In-Network	In-Network	In-Network
Deductible				
Individual / Family	\$4,000 / \$8,000 Embedded	\$4,000 / \$8,000 Embedded	\$3,000 / \$6,000 Embedded	\$2,000 / \$4,000 Aggregate
Coinsurance	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Out-of-Pocket Maximum	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance
Individual / Family	\$6,000 / \$12,000 Embedded	\$6,000 / \$12,000 Embedded	\$6,000 / \$12,000 Embedded	\$5,000 / \$10,000 Embedded
Preventive Care	Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW
Office Visit				After deductible is met
Primary Care	\$30 copay DW	\$30 copay DW	\$30 copay DW	20% Preferred
Specialist	\$65 copay DW	\$65 copay DW	\$65 copay DW	20% Preferred
Urgent Care	\$40 copay DW	\$40 copay DW	\$40 copay DW	20% Preferred
Virtual Care Provider	Covered in full DW	Covered in full DW	Covered in full DW	20% Preferred
Chiropractic / Acupuncture ⁽¹⁾	\$30 copay DW	\$30 copay DW	\$30 copay DW	20% Preferred
X-Ray & Lab	After deductible is met	After deductible is met	After deductible is met	After deductible is met
Diagnostic Lab	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Diagnostic X-Ray	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Complex - MRI, PET, CAT, CT	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Hospitalization	After deductible is met	After deductible is met	After deductible is met	After deductible is met
Inpatient Facility	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Outpatient Surgery	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Emergency Room	\$100 copay, then 20% Preferred	\$200 copay, then 20% Preferred	\$200 copay, then 20% Preferred	20% Preferred
Prescription Drugs	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply
Formulary	Essentials E4	Essentials E4	Essentials E4	Essentials E1
Deductible	\$0	\$0	\$0	Medical Deductible
Out-of-Pocket Maximum	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.
Brand/Preferred Specialty/Non-Preferred Specialty	\$15 / \$30 / \$50 / 30%	\$15 / \$30 / \$60 / 30%	\$15 / \$30 / \$60 / 30%	20% Preferred
Vision	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year
Exam	10% DW	10% DW	10% DW	10% DW
Hardware	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)
Non-Network**	Non-Network**	Non-Network**	Non-Network**	Non-Network**
Deductible (Individual / Family)	\$8,000 / \$16,000 Embedded	\$8,000 / \$16,000 Embedded	\$6,000 / \$12,000 Embedded	Shared with In-Network
Out-of-Pocket Maximum (Individual / Family)	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded
Coinsurance	60%	60%	60%	60%
Rates	Current	Renewal	Option 3	Option 4
Employee Only (EE)	23 \$975.54	\$1,068.22	\$1,084.99	\$1,074.75
EE & Spouse	2 \$2,194.97	\$2,403.50	\$2,441.23	\$2,418.17
EE & Child(ren)	9 \$1,707.18	\$1,869.37	\$1,898.72	\$1,880.79
EE & Spouse & Child(ren)	1 \$2,896.62	\$3,204.68	\$3,254.98	\$3,224.23
Total	35			
Total Premiums				
Total Monthly	\$45,089	\$49,405	\$50,181	\$49,707
Total Annual	\$541,063	\$592,861	\$602,168	\$596,483
Annual % Change		9.57%	11.29%	10.24%
Annual \$ Change		\$51,798	\$61,105	\$55,420

DW = Deductible Waived

*Enrollment is based on Premera 2026 renewal. Rates are subject to change based on final enrollment.

**Additional Non-Network benefits may be available. More information is available if requested.

1. Visits have limits.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from rates provided. This is a illustration for financial comparative purposes only.

Medical Comparison

Effective Date 7/1/2026

	Current	Renewal	Option 5	Option 6
	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross	Premera Blue Cross
	Preferred Choice Plus 4000	Preferred Choice Plus 4000	Preferred Choice HSA EMB 3400 Essentials	Preferred Choice HSA EMB 4000 Essentials
Network	Heritage	Heritage	Heritage	Heritage
HRA Employer Contribution	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.
Benefit Type	In-Network	In-Network	In-Network	In-Network
Deductible				
Individual / Family	\$4,000 / \$8,000 Embedded	\$4,000 / \$8,000 Embedded	\$3,400 / \$6,800 Embedded	\$4,000 / \$8,000 Embedded
Coinsurance	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Out-of-Pocket Maximum	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance	Includes: Deductible, copays, and coinsurance
Individual / Family	\$6,000 / \$12,000 Embedded	\$6,000 / \$12,000 Embedded	\$5,000 / \$10,000 Embedded	\$6,000 / \$12,000 Embedded
Preventive Care	Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW
Office Visit			After deductible is met	After deductible is met
Primary Care	\$65 copay (\$30 copay Designated PCP) DW	\$65 copay (\$30 copay Designated PCP) DW	20% Preferred	20% Preferred
Specialist	\$65 copay DW	\$65 copay DW	20% Preferred	20% Preferred
Urgent Care	\$40 copay DW	\$40 copay DW	20% Preferred	20% Preferred
Virtual Care Provider	Covered in full DW	Covered in full DW	20% Preferred	20% Preferred
Chiropractic / Acupuncture ⁽¹⁾	\$30 copay DW	\$30 copay DW	20% Preferred	20% Preferred
X-Ray & Lab	After deductible is met	After deductible is met	After deductible is met	After deductible is met
Diagnostic Lab	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Diagnostic X-Ray	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Complex - MRI, PET, CAT, CT	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Hospitalization	After deductible is met	After deductible is met	After deductible is met	After deductible is met
Inpatient Facility	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Outpatient Surgery	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20% Preferred / 40% Participating
Emergency Room	\$100 copay, then 20% Preferred	\$200 copay, then 20% Preferred	20% Preferred	20% Preferred
Prescription Drugs	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply
Formulary	Essentials E4	Essentials E4	Essentials E1	Essentials E1
Deductible	\$0	\$0	Medical Deductible	Medical Deductible
Out-of-Pocket Maximum	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.	Included with medical; accrues to OOP max.
Preferred Generic/Preferred	\$15 / \$30 / \$50 / 30%	\$15 / \$30 / \$60 / 30%	20% Preferred	20% Preferred
Brand/Preferred Specialty/Non-Preferred all drugs				
Vision	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year	Vision Exam/Test and Hardware \$350 combined max. per calendar year
Exam	10% DW	10% DW	10% DW	10% DW
Hardware	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)
Non-Network**	Non-Network**	Non-Network**	Non-Network**	Non-Network**
Deductible (Individual / Family)	\$8,000 / \$16,000 Embedded	\$8,000 / \$16,000 Embedded	Shared with In-Network	Shared with In-Network
Out-of-Pocket Maximum (Individual / Family)	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded
Coinsurance	60%	60%	60%	60%
Rates	rollment*	Current	Renewal	Option 5
Employee Only (EE)	23	\$975.54	\$1,068.22	\$1,037.23
EE & Spouse	2	\$2,194.97	\$2,403.50	\$2,333.77
EE & Child(ren)	9	\$1,707.18	\$1,869.37	\$1,815.14
EE & Spouse & Child(ren)	1	\$2,896.62	\$3,204.68	\$3,111.69
Total	35			
Total Premiums				
Total Monthly		\$45,089	\$49,405	\$47,972
Total Annual		\$541,063	\$592,861	\$575,661
Annual % Change			9.57%	6.39%
Annual \$ Change			\$51,798	\$34,598

DW = Deductible Waived

*Enrollment is based on Premera 2026 renewal. Rates are subject to change based on final enrollment.

**Additional Non-Network benefits may be available. More information is available if requested.

1. Visits have limits.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from the plan provided. This is a illustration for financial control purposes only.

Exhibit A to Resolution 26-23 for RCOM May 20, 2026

Medical Comparison

Effective Date 7/1/2026

	Current	Renewal	Option 7	Option 8	
	Premera Blue Cross	Premera Blue Cross	Aetna Sm. Group Level-Funded ²	Aetna Sm. Group Level-Funded ²	
	Preferred Choice Plus 4000	Preferred Choice Plus 4000	AFA CPOSII 4000 80/50 \$0LXR	AFA CPOSII 2500 80/50 \$0LXR	
Network	Heritage	Heritage	CPOSII	CPOSII	
HRA Employer Contribution	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	HRA reimburses 80% after \$1,500 in deductible expenses, up to \$2,000 per Employee; and up to \$4,000 per Family.	
Benefit Type	In-Network	In-Network	In-Network	In-Network	
Deductible	Individual / Family \$4,000 / \$8,000 Embedded	Individual / Family \$4,000 / \$8,000 Embedded	Individual / Family \$4,000 / \$8,000	Individual / Family \$2,500 / \$5,000	
Coinsurance	20% Preferred / 40% Participating	20% Preferred / 40% Participating	20%	20%	
Out-of-Pocket Maximum	Includes: Deductible, copays, and coinsurance Individual / Family \$6,000 / \$12,000 Embedded	Includes: Deductible, copays, and coinsurance Individual / Family \$6,000 / \$12,000 Embedded	Includes: Deductible, copays, and coinsurance Individual / Family \$7,350 / \$14,700	Includes: Deductible, copays, and coinsurance Individual / Family \$6,500 / \$13,000	
Preventive Care	Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW	
Office Visit	Primary Care \$65 copay (\$30 copay Designated PCP) DW Specialist \$65 copay DW Urgent Care \$40 copay DW Virtual Care Provider Covered in full DW Chiropractic / Acupuncture ⁽¹⁾ \$30 copay DW	Primary Care \$65 copay (\$30 copay Designated PCP) DW Specialist \$65 copay DW Urgent Care \$40 copay DW Virtual Care Provider Covered in full DW Chiropractic / Acupuncture ⁽¹⁾ \$30 copay DW	Primary Care \$35 copay DW Specialist \$75 copay DW Urgent Care \$75 copay DW Virtual Care Provider Covered in full DW Chiropractic / Acupuncture ⁽¹⁾ \$75 copay DW	Primary Care \$35 copay DW Specialist \$75 copay DW Urgent Care \$75 copay DW Virtual Care Provider Covered in full DW Chiropractic / Acupuncture ⁽¹⁾ \$75 copay DW	
X-Ray & Lab	Diagnostic Lab 20% Preferred / 40% Participating Diagnostic X-Ray 20% Preferred / 40% Participating Complex - MRI, PET, CAT, CT 20% Preferred / 40% Participating	Diagnostic Lab 20% Preferred / 40% Participating Diagnostic X-Ray 20% Preferred / 40% Participating Complex - MRI, PET, CAT, CT 20% Preferred / 40% Participating	Diagnostic Lab Covered in full DW Diagnostic X-Ray Covered in full DW Complex - MRI, PET, CAT, CT 20% after deductible	Diagnostic Lab Covered in full DW Diagnostic X-Ray Covered in full DW Complex - MRI, PET, CAT, CT 20% after deductible	
Hospitalization	Inpatient Facility 20% Preferred / 40% Participating Outpatient Surgery 20% Preferred / 40% Participating Emergency Room \$100 copay, then 20% Preferred	Inpatient Facility 20% Preferred / 40% Participating Outpatient Surgery 20% Preferred / 40% Participating Emergency Room \$200 copay, then 20% Preferred	Inpatient Facility 20% after deductible Outpatient Surgery 20% after deductible Emergency Room \$300 copay, then 20% after deductible	Inpatient Facility 20% after deductible Outpatient Surgery 20% after deductible Emergency Room \$300 copay, then 20% after deductible	
Prescription Drugs	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply Formulary Deductible Essentials E4 \$0 Out-of-Pocket Maximum Included with medical; accrues to OOP max. Preferred Generic/Preferred Brand/Preferred Specialty/Non-Preferred all drugs \$15 / \$30 / \$50 / 30%	Retail: 90 days, if applicable one copay every 30 day supply Specialty: Up to 30-day supply Formulary Deductible Essentials E4 \$0 Out-of-Pocket Maximum Included with medical; accrues to OOP max. Preferred Generic/Preferred Brand/Preferred Specialty/Non-Preferred all drugs \$15 / \$30 / \$60 / 30%	Retail: up to 30 day supply Aetna National Pharmacy \$0 Included with medical; accrues to OOP max. \$10 / \$50 / \$80 / 20% (max. \$250) / 40% (max. \$500)	Retail: up to 30 day supply Aetna National Pharmacy \$0 Included with medical; accrues to OOP max. \$10 / \$50 / \$80 / 20% (max. \$250) / 40% (max. \$500)	
Vision	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW Exam Hardware Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Vision Exam/Test and Hardware \$350 combined max. per calendar year 10% DW Exam Hardware Frames: 1 set every 2 years (\$90 max.) Lenses: 1 pair every year (\$170 max.)	Exam Covered in full DW; one exam every 12 months Hardware Not Covered	Exam Covered in full DW; one exam every 12 months Hardware Not Covered	
Non-Network**	Non-Network**	Non-Network**	Non-Network**	Non-Network**	
Deductible (Individual / Family)	\$8,000 / \$16,000 Embedded	\$8,000 / \$16,000 Embedded	\$8,000 / \$24,000	\$5,000 / \$15,000	
Out-of-Pocket Maximum (Individual / Family)	\$45,000 / \$90,000 Embedded	\$45,000 / \$90,000 Embedded	\$23,000 / \$69,000	\$15,000 / \$45,000	
Coinsurance	60%	60%	50%	50%	
Rates	rollment*	Current	Renewal	Option 7	Option 8
Employee Only (EE)	23	\$975.54	\$1,068.22	\$756.52	\$819.80
EE & Spouse	2	\$2,194.97	\$2,403.50	\$1,783.20	\$1,946.10
EE & Child(ren)	9	\$1,707.18	\$1,869.37	\$1,625.23	\$1,772.82
EE & Spouse & Child(ren)	1	\$2,896.62	\$3,204.68	\$2,572.98	\$2,812.49
Total	35				
Total Premiums					
Total Monthly	\$45,089	\$49,405	\$38,166	\$41,515	
Total Annual	\$541,063	\$592,861	\$457,997	\$498,186	
Annual % Change		9.57%	-15.35%	-7.92%	
Annual \$ Change		\$51,798	-\$83,066	-\$42,878	

DW = Deductible Waived

*Enrollment is based on Premera 2026 renewal. Rates are subject to change based on final enrollment.

**Additional Non-Network benefits may be available. More information is available if requested.

1. Visits have limits.

2. Aetna level-funded details: ISL - \$20,000, ASL - 120%, Unlimited Stop Loss Max, 12/12 contract w/ 48 month run-out, 50% surplus return

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be

aware that carriers may revise rates upon enrollment if enrollment differs from the data provided. This is an illustration of financial consequences only.

Exhibit A to Resolution 26-23 for RCGM May 20, 2026

Dental Comparison

Effective Date 7/1/2026

	Current / Renewal		Option 1	Option 2	Option 3	Option 4	
	Premera Blue Cross		Principal	Principal	Principal	Principal	
	PC Optima 1500 Enhanced + AMW		Dental PPO	Dental PPO	Dental PPO	Dental PPO	
Participation Requirement	Current		50% participation	50% participation	50% participation	50% participation	
Network	Dental Choice		Principal PPO	Principal PPO	Principal PPO	Principal PPO	
Waiting Period	None		None	None	None	None	
Deductible	Calendar Year		Calendar Year	Calendar Year	Calendar Year	Calendar Year	
Yearly Accumulation	\$50		\$50	\$50	\$50	\$50	
Individual	\$150		\$150	\$150	\$150	\$150	
Family							
Annual Maximum	\$1,500		\$1,500	\$1,500	\$2,000	\$2,000	
Deductible Waived for Preventive?	Yes		Yes	Yes	Yes	Yes	
Preventive	Covered in full DW		Covered in full DW	Covered in full DW	Covered in full DW	Covered in full DW	
Exams, Cleanings, X-rays, Sealants							
Basic Services	After deductible is met		After deductible is met	After deductible is met	After deductible is met	After deductible is met	
Fillings	20%		20%	20%	20%	20%	
Simple Extractions	20%		20%	20%	20%	20%	
Periodontics	20%		20%	20%	20%	20%	
Endodontics	20%		20%	20%	20%	20%	
Major Services	After deductible is met		After deductible is met	After deductible is met	After deductible is met	After deductible is met	
Crowns, Inlay, Outlays	50%		50%	50%	50%	50%	
Bridges	50%		50%	50%	50%	50%	
Implants	50%		50%	50%	50%	50%	
Orthodontia	Not Covered		50%	50%	50%	50%	
Coverage	N/A		Child Only	Adult and Child	Child Only	Adult and Child	
Those Eligible	N/A		\$1,000	\$1,000	\$1,000	\$1,000	
Lifetime Maximum							
Coverage: Out-of-Network	Covered in full DW / 20% / 50%		Covered in full DW / 20% / 50%	Covered in full DW / 20% / 50%	Covered in full DW / 20% / 50%	Covered in full DW / 20% / 50%	
Preventive/Basic/Major	80th percentile (in-state)		90th percentile	90th percentile	90th percentile	90th percentile	
Reimbursement	90th percentile (out-of-state)						
Rates	Enrollment*	Current	Renewal	Option 1	Option 2	Option 3	Option 4
Employee Only (EE)	23	\$40.29	\$43.51	\$43.13	\$44.63	\$45.36	\$46.86
EE & Spouse	1	\$86.62	\$93.54	\$88.35	\$91.47	\$92.85	\$95.97
EE & Child(ren)	12	\$88.64	\$95.72	\$112.95	\$114.45	\$117.83	\$119.33
EE & Spouse & Child(ren)	3	\$132.96	\$143.59	\$166.51	\$169.63	\$174.00	\$177.12
Total	39						
	<i>Rate guaranteed until</i>		<i>7/1/2027</i>	<i>7/1/2027</i>	<i>7/1/2027</i>	<i>7/1/2027</i>	<i>7/1/2027</i>
Total Premiums							
Total Monthly		\$2,476	\$2,674	\$2,935	\$3,000	\$3,072	\$3,137
Total Annual		\$29,710	\$32,084	\$35,223	\$36,003	\$36,865	\$37,645
Annual % Change			7.99%	18.56%	21.18%	24.08%	26.71%
Annual \$ Change			\$2,374	\$5,513	\$6,293	\$7,155	\$7,935

DW = Deductible Waived

*Enrollment is based on Premera 2026 renewal.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Voluntary Vision Comparison

Effective Date 7/1/2026

	Option 1	Option 2	Option 3	Option 4
	Principal	Principal	Principal	Principal
	Voluntary PPO Plan	Voluntary PPO Plan	Voluntary PPO Plan	Voluntary PPO Plan
Participation Requirement	Greater of 20% or 5 lives	Greater of 20% or 5 lives	Greater of 20% or 5 lives	Greater of 20% or 5 lives
Network	VSP Choice	VSP Choice	VSP Choice	VSP Choice
Frequencies				
Exam	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 24 months	Once every 12 months	Once every 24 months
Contacts (in lieu of glasses)	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Copays				
Exam Visit	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Hardware	\$25 copay	\$25 copay	\$25 copay	\$25 copay
Lenses				
Single Vision	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay
Standard Bifocal	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay
Standard Trifocal	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay	Covered with hardware copay
Progressive	\$0 (standard progressive lenses)	\$0 (standard progressive lenses)	\$0 (standard progressive lenses)	\$0 (standard progressive lenses)
Frames				
Frame Allowance	\$200 / 20% savings on amount over allowance	\$200 / 20% savings on amount over allowance	\$250 / 20% savings on amount over allowance	\$250 / 20% savings on amount over allowance
Contacts				
Fitting & Evaluation	Up to \$60 copay	Up to \$60 copay	Up to \$60 copay	Up to \$60 copay
Elective (in lieu of glasses)	\$200 allowance	\$200 allowance	\$250 allowance	\$250 allowance
Medically Necessary	Covered in full after \$25 copay	Covered in full after \$25 copay	Covered in full after \$25 copay	Covered in full after \$25 copay
Out of Network Reimbursement	Up to \$30 - \$210	Up to \$30 - \$210	Up to \$30 - \$210	Up to \$30 - \$210
Rates	Option 1	Option 2	Option 3	Option 4
Enrollment*				
Employee Only (EE)	23	\$9.70	\$8.64	\$10.67
EE & Spouse	2	\$21.15	\$18.81	\$23.22
EE & Child(ren)	9	\$16.85	\$15.14	\$18.52
EE & Spouse & Child(ren)	1	\$29.73	\$26.60	\$32.65
Total	35			
<i>Rate guaranteed until</i>	<i>7/1/2028</i>	<i>7/1/2028</i>	<i>7/1/2028</i>	<i>7/1/2028</i>
Total Premiums				
Total Monthly	\$447	\$399	\$491	\$436
Total Annual	\$5,361	\$4,790	\$5,894	\$5,232

*Enrollment is based on Premera 2026 renewal.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Effective Date 7/1/2026

	Current / Renewal		Option 1
	UNUM		Principal
Benefit Classification	Class 1: Full-Time Employees Class 2: Part-Time Employees		Class 1: Full-Time Employees Class 2: Part-Time Employees
Benefit Amount (Employee)			
Maximum Benefit	\$25,000		\$25,000
Guaranteed Issue	\$25,000		\$25,000
Benefit Amount (Dependents)			
Spouse	\$1,000		\$2,000
Child	\$1,000		\$1,000
Contract Features			
Waiver of Premium	Included		Included
Conversion	Not included		Included
Portability	Included		Not included
Accelerated Benefit	100% of life benefit		75% of life benefit
Employee Assistance Program	Included		Not included
AD&D			
Principal Sum	Matches life amount		Matches life amount
Travel Assistance	Included		Included
Age Reduction	% of Original Amount		% of Original Amount
At Age 70	65%		65%
At Age 75	50%		50%
Enrollment <u>49</u>	Current	Renewal	Option 1¹
Benefit Volume*	\$1,225,000	\$1,225,000	\$1,225,000
Life Rate per \$1,000	\$0.251	\$0.251	\$0.210
AD&D Rate per \$1,000	\$0.050	\$0.050	\$0.029
Total Rate per \$1,000	\$0.301	\$0.301	\$0.239
Dependent Life Rate per dep. unit	\$0.590	\$0.590	\$0.400
<i>Rate guaranteed until</i>		<i>7/1/2027</i>	<i>7/1/2028</i>
Premiums			
Total Monthly	\$375	\$375	\$293
Total Annual	\$4,503	\$4,503	\$3,513
Annual % Change		0.00%	-21.97%
Annual \$ Change		\$0	-\$989

*Volume based on UNUM May 2026 Invoice.

1. Dep. Life rates not included - need breakout of spouse vs. child enrollment as Life amounts differ

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Voluntary Life/AD&D Comparison

Effective Date 7/1/2026

	Current / Renewal		Option 1
	UNUM		Principal
Participation Requirement	Current		Greater of 20% or 5 lives
For Employee			
Benefit Increments	\$10,000		\$10,000
Maximum Benefit	\$60,000		\$500,000
Guaranteed Issue	\$60,000		Under age 70: \$150,000 Age 70+: \$10,000
For Spouse			
Benefit Increments	\$5,000		\$5,000
Maximum Benefit	\$60,000		\$150,000; cannot exceed 100% of EE amount
Guaranteed Issue	\$25,000		Under age 70: \$30,000 Age 70+: \$10,000
For Children			
Infant Benefit	Birth to 6 mo: \$1,000		
Benefit Increments	\$2,000		Benefit amounts of \$2,000, \$4,000 or \$10,000
Maximum Benefit	\$10,000		
Guaranteed Issue	\$10,000		All amounts
Contract Features			
Matching AD&D	Included; Optional		Included; Compulsory
Waiver of Premium	Included		Included
Conversion	Included		Included
Portability	Included		Included
Accelerated Benefit	75% of life amount to max. of \$500,000		75% of life amount up to \$250,000
Age Reduction	% of Original Amount		% of Original Amount
At Age 70	65%		65%
At Age 75	50%		50%
Employee Life per \$10,000 / Spouse Life per \$5,000	Current Employee/Spouse	Renewal Employee/Spouse	Employee/Spouse Life per \$1,000
Under 20	\$0.700 / \$0.350	\$0.700 / \$0.350	\$0.080
20 - 24	\$0.700 / \$0.350	\$0.700 / \$0.350	\$0.080
25 - 29	\$0.800 / \$0.400	\$0.800 / \$0.400	\$0.080
30 - 34	\$1.040 / \$0.520	\$1.040 / \$0.520	\$0.104
35 - 39	\$1.500 / \$0.750	\$1.500 / \$0.750	\$0.150
40 - 44	\$2.300 / \$1.150	\$2.300 / \$1.150	\$0.230
45 - 49	\$3.800 / \$1.900	\$3.800 / \$1.900	\$0.380
50 - 54	\$5.100 / \$2.550	\$5.100 / \$2.550	\$0.510
55 - 59	\$7.500 / \$3.750	\$7.500 / \$3.750	\$0.750
60 - 64	\$9.800 / \$4.900	\$9.800 / \$4.900	\$0.980
65 - 69	\$13.600 / \$6.800	\$13.600 / \$6.800	\$1.360
70 - 74	\$26.000 / \$13.000	\$26.000 / \$13.000	\$2.600
75+	\$77.200 / \$38.600	\$77.200 / \$38.600	\$2.600
Employee AD&D per \$10,000	\$0.500	\$0.500	Per \$1,000
Spouse AD&D per \$5,000	\$0.250	\$0.250	Per \$1,000
Spouse Rate Based On	Spouse Age	Spouse Age	Spouse Age
Child Coverage			
Life per \$2,000	\$0.700	\$0.700	\$2,000 - \$0.40/family \$4,000 - \$0.80/family \$10,000 - \$2.00/family
AD&D per \$1,000	\$0.100	\$0.100	Not applicable
<i>Rate guaranteed until</i>	<i>7/1/2027</i>		<i>7/1/2028</i>

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Exhibit A to Resolution 26-23 for RCCM May 20, 2026

City of Kotzebue

Short Term Disability Comparison



Effective Date 7/1/2026

		Option 1
		UNUM
Benefit Classification		All full-time employees
Benefit Amount		
Benefits Percentage		60%
Maximum Weekly Benefit		\$1,500
Benefit Period		
Elimination Period		
Accident		14 days
Illness		14 days
Max Benefit Duration		11 weeks
Definition of Disability		
Total Disability		The employee is limited from performing the material and substantial duties of his or her regular occupation due to his or her sickness or injury; and the employee has a 20% or more loss in weekly earnings due to the same sickness or injury
Partial Disability		
Other Contract Features		
W-2 Preparation		Included
Employer FICA Match		Not included
Preexisting Limitation		None
Enrollment	<u>70</u>	Option 1
Covered Weekly Benefit*		\$6,372
STD Rate Per \$10		\$0.180
	<i>Rate guaranteed until</i>	<i>7/1/2028</i>
Premiums		
Total Monthly		\$115
Total Annual		\$1,376

*Covered Weekly Benefit based on employer 2026 census data provided.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Exhibit A to Resolution 26-23 for RCCM May 20, 2026

City of Kotzebue
Long Term Disability Comparison



Effective Date 7/1/2026

	Option 1
	UNUM
Benefit Classification	All full-time employees
Benefit Amount	
Monthly Benefit Percentage	66.67%
Maximum Monthly Benefit	\$7,000
Minimum Monthly Benefit	Greater of \$100 or 10% of gross disability payment
Guaranteed Issue	\$7,000
Benefit Period	
Elimination Period	90 days
Own Occupation Period	2 years
Mental/Nervous Limit	24 Months
Substance Abuse Limit	24 Months
Benefit Duration	Social security normal retirement age (SSNRA)
Definition of Disability	
Total Disability	The employee is limited from performing the material and substantial duties of his or her regular occupation due to his or her sickness or injury; and the employee has a 20% or more loss in his or her indexed monthly earnings due to the same sickness or injury.
Partial Disability	
Other Contract Features	
Survivor Income	3 times gross monthly benefit
Preexisting Limitation	3 / 12
Conversion	Not included
Return to Work Incentive	12 months
Employee Assistance Program	Included
Value-Added Program	
FICA Match	Included
W-2 Preparation	Included
Enrollment	Option 1
Covered Monthly Payroll*	\$459,834
LTD Rate Per \$100	\$0.420
<i>Rate guaranteed until</i>	7/1/2028
Premiums	
Total Monthly	\$1,931
Total Annual	\$23,176

*Covered Monthly Payroll based on employer 2026 census data provided.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial purposes only.

Health Savings Account Comparison

Effective Date 7/1/2026

	Option 1	Option 2	Option 3
	HRPro, Inc.	PeakOne	Benefit Help Solutions
Annual Fees			
Initial Set-up Fee	\$10	\$0	\$50
Annual Renewal Fee	\$0	Included in HRA	\$0
Debit Cards	Includes 2 debit cards per employee (\$10 fee for additional or replacement)	Included	Included
Employer Contribution⁽¹⁾			
Individual	TBD	TBD	TBD
Family	TBD	TBD	TBD
Monthly Fees			
Per Member Per Month	\$2.30	\$3.09	\$2.95
Minimum Monthly Billing Fee	\$0	\$0	\$0
Estimated Employee Count: <u>15</u>			
Total Base Monthly	Option 1 \$35	Option 2 \$46	Option 3 \$44
Total Estimated Annual Fee	\$424	\$556	\$581
<i>Rate guaranteed until</i>	<i>7/1/2027</i>	<i>7/1/2027</i>	<i>7/1/2027</i>

1. Employer contributions are not included in the total administration fee.
HSA Enrollment is estimated.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Health Reimbursement Arrangement Comparison

Effective Date 7/1/2026

	Current	Renewal	Option 1	Option 2
	Benefit Help Solutions	Benefit Help Solutions	HRPro, Inc.	PeakOne
Administrative Services				
Summary Plan Description	Included	Included	Included	Included
Enrollment Materials	Printed materials & enrollment packets \$1.50 each	Printed materials & enrollment packets \$1.50 each	Included	Included
Non-Discrimination Testing	Included	Included	Available through partner solution (additional fee)	\$150 per test
Additional Services				
Paper Enrollment	\$5.00 fee for any paper enrollment received	\$5.00 fee for any paper enrollment received	Included	Included
Employer Funding				
Individual	\$2,000	\$2,000	\$2,000	\$2,000
Family	\$4,000	\$4,000	\$4,000	\$4,000
Annual Fees				
Initial Set-up Fee	\$0	\$0	\$350	\$0
Annual Renewal Fee	\$255	\$260	\$300	\$300
Monthly Fees				
Per Member Per Month	\$5.50	\$5.75	\$4.50	\$4.19
Minimum Monthly Billing Fee	\$105	\$110	\$100	\$0
Estimated Employee Count: 24				
Total Base Monthly	Current \$132	Renewal \$138	Option 1 \$108	Option 2 \$101
Total Estimated Annual Fee	\$1,839	\$1,916	\$1,946	\$1,507
Annual % Change		4.19%	5.82%	-18.07%
Annual \$ Change		\$77	\$107	-\$332
		7/1/2027	7/1/2027	7/1/2027
	<i>Rate guaranteed until</i>			

Enrollment is based on BHS May 2026 enrollment report.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

COBRA Administration Comparison

Effective Date 7/1/2026

	Option 1 HRPro, Inc.	Option 2 PeakOne	Option 3 Benefit Help Solutions
COBRA Notices			
Qualifying Event Notice	Included	Included	Included / Initial notice fee - \$3.75
Open Enrollment Packet	Included (by request)	Included	\$10
Annual Fees			
Initial Set-up Fee	\$0	\$0	\$0
Annual Renewal Fee	\$0	Included in HRA	\$300
Monthly Fees			
Per Eligible Employee Per Month	\$0.70	\$0.99	\$1.10
2% Administrative Fee Retained By	HRPro, Inc.	PeakOne	Benefit Help Solutions
Minimum Monthly Billing Fee	\$35	\$0	\$95
Estimated Employee Count: <u>74</u>			
Total Base Monthly	Option 1 \$52	Option 2 \$73	Option 2 \$81
Total Estimated Annual Fee	\$622	\$879	\$977
<i>Rate guaranteed until</i>	<i>7/1/2027</i>	<i>7/1/2027</i>	<i>7/1/2027</i>

Enrollment is based on employer 2026 census data provided.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.

Employee Assistance Program (EAP) Comparison

Effective Date 7/1/2026

	Current / Renewal	
	First Choice EAP	
Counseling Services		
Visits (Virtual / In Person)	Up to 5 sessions per person per unique problem per year	
Telephonic	Included	
Web Access	Included	
Critical Incident/Trauma	Included	
Legal Services	Included	
Financial Services	Included	
Identity Theft	Included	
Management Services		
Critical Incident Stress Debriefings	Critical Incident On-site Support and Crisis Response Consultation (2 hours per year). Addl on-site support \$250/hour. Addl on-site orientations \$160/hour.	
Supervisor Consultations	Live virtual Orientations (1 per year); Pre-recorded online orientations included. Customized Management/Leadership Training (on-site or webinar) \$225-\$350/hour. Additional benefit/wellness/safety fairs \$160/hour.	
Estimated Employee Count <u>70</u>	Current	Renewal
Cost per Employee Per Month	\$2.30	\$2.30
Premiums		
Total Monthly	\$161	\$161
Total Annual	\$1,932	\$1,932
Annual % Change		0.00%
Annual \$ Change		\$0
<i>Rate guaranteed until</i>		7/1/2027

Enrollment is based on First Choice enrollment info. as of 5/2026.

For complete details please refer to the Benefit Summary. All plan changes may not be reflected above. Any discrepancy between this illustration and the contract will be governed by the contract. Final rates are based upon actual enrollment. Please be aware that carriers may revise rates upon enrollment if enrollment differs from census provided. This is an illustration for financial comparative purposes only.