SCHEDULE OF HEALTH/LIFE/DENTAL CONTRIBUTIONS
FY 2027

HEALTH PLAN	PLAN TYPE	COVERAGE	60/40 Split for Active Employees Only (Temporary FY27) 52 WKS	36 WKS	26 WKS	21 WKS	18 WKS	MONTHLY	50/50 Split Retirees Only MONTHLY	COBRA
Harvard Pilgrim Access America	PPO	Individual	$139.51	$201.51	$279.01	$345.44	$403.02	$604.53	$755.66	$1,537.69
		Family	$311.42	$449.82	$622.83	$771.12	$899.65	$1,349.47	$1,686.84	$3,432.54
Wellpoint Total Choice (formerly Unicare)	Indemnity	Individual	$168.68	$243.65	$337.37	$417.69	$487.31	$730.96	$913.70	$1,859.29
		Family	$375.31	$542.12	$750.63	$929.35	$1,084.24	$1,626.36	$2,032.96	$4,136.86
Wellpoint PLUS (formerly Unicare)	PPO-type	Individual	$107.18	$154.81	$214.36	$265.39	$309.62	$464.44	$580.55	$1,181.35
		Family	$256.45	$370.43	$512.90	$635.02	$740.85	$1,111.28	$1,389.10	$2,826.68
Harvard Pilgrim Explorer	POS	Individual	$119.19	$172.17	$238.38	$295.14	$344.33	$516.50	$645.62	$1,313.77
		Family	$295.66	$427.06	$591.32	$732.11	$854.13	$1,281.19	$1,601.49	$3,258.87
Mass General Brigham Health Plan Complete	HMO	Individual	$113.95	$164.59	$227.89	$282.15	$329.18	$493.77	$617.21	$1,255.96
		Family	$302.54	$437.00	$605.07	$749.14	$873.99	$1,310.99	$1,638.74	$3,334.67
Health New England	HMO	Individual	$83.28	$120.30	$166.57	$206.22	$240.59	$360.89	$451.12	$917.97
		Family	$200.32	$289.35	$400.64	$496.04	$578.71	$868.06	$1,085.08	$2,208.03
Wellpoint Community Choice (formerly Unicare)	PPO-type	Individual	$83.42	$120.50	$166.84	$206.56	$240.99	$361.49	$451.86	$919.49
		Family	$208.27	$300.83	$416.53	$515.71	$601.66	$902.48	$1,128.11	$2,295.58
Harvard Pilgrim Quality	HMO	Individual	$89.23	$128.88	$178.45	$220.94	$257.77	$386.65	$483.32	$983.50
		Family	$227.59	$328.74	$455.17	$563.55	$657.47	$986.21	$1,232.76	$2,508.54
MEDICARE PLANS										
Tufts Health Plan Medicare Preferred	Medicare Advantage		N/A	N/A	N/A	N/A	N/A	$203.41	$203.41	N/A
Wellpoint Medicare Extension (formerly Unicare)	Medicare Supplement		N/A	N/A	N/A	N/A	N/A	$248.86	$248.86	N/A
Harvard Pilgrim Medicare Enhanced	Medicare Supplement		N/A	N/A	N/A	N/A	N/A	$251.75	$251.75	N/A
Health New England Medicare Supplement Plus	Medicare Supplement		N/A	N/A	N/A	N/A	N/A	$252.72	$252.72	N/A

DENTAL INSURANCE

			52 WKS	36 WKS	26 WKS	21 WKS	18 WKS	MONTHLY	COBRA
Delta Dental PPO Plus Premier (Active Employees)	Premier	Individual	$12.46	$18.00	$24.92	$30.86	$36.00	$54.00	$55.08
		Family	$31.62	$45.67	$63.23	$78.29	$91.33	$137.00	$139.74
Delta Dental Voluntary Table Plan (Retirees)		Individual						$40.00	
		Family						$99.00	

LIFE INSURANCE

Provider		Type	Coverage		Monthly Deduction
Boston Mutual	1	Basic Term	10,000	$ 9.75	52 wk.
		G-142		$ 11.70	21-33 wk.

Boston Mutual	2	Voluntary Term Life G-13964-1 (Closed)		52 WKS	36 WKS	26 WKS	21 WKS	18 WKS	MONTHLY
			$ 5,000	$ 0.90	$ 1.30	$ 1.80	$ 2.23	$ 2.60	$ 3.90
			$ 10,000	$ 1.80	$ 2.60	$ 3.60	$ 4.46	$ 5.20	$ 7.80
			$ 15,000	$ 2.70	$ 3.90	$ 5.40	$ 6.69	$ 7.80	$ 11.70
			$ 20,000	$ 3.60	$ 5.20	$ 7.20	$ 8.91	$ 10.40	$ 15.60
			$ 25,000	$ 4.50	$ 6.50	$ 9.00	$ 11.14	$ 13.00	$ 19.50
			$ 30,000	$ 5.40	$ 7.80	$ 10.80	$ 13.37	$ 15.60	$ 23.40
			$ 35,000	$ 6.30	$ 9.10	$ 12.60	$ 15.60	$ 18.20	$ 27.30
			$ 40,000	$ 7.20	$ 10.40	$ 14.40	$ 17.83	$ 20.80	$ 31.20
		Dependent Coverage		$ 1.00	$ 1.44	$ 2.00	$ 2.48	$ 2.89	$ 4.33

Boston Mutual — 3 — Voluntary Term Life & Acc. Death G-13964-2

Sample weekly payroll deductions for you and your spouse are shown below.

Age	Monthly Premium Rate per 1,000	10,000	30,000	50,000	100,000
Under 35	$ 0.12	$ 0.28	$ 0.83	$ 1.38	$ 2.77
35-39	$ 0.16	$ 0.37	$ 1.11	$ 1.85	$ 3.69
40-44	$ 0.24	$ 0.55	$ 1.66	$ 2.77	$ 5.54
45-49	$ 0.35	$ 0.81	$ 2.42	$ 4.04	$ 8.08
50-54	$ 0.56	$ 1.29	$ 3.88	$ 6.46	$ 12.92
55-59	$ 0.78	$ 1.80	$ 5.40	$ 9.00	$ 18.00
60-64	$ 1.14	$ 2.63	$ 7.89	$ 13.15	$ 26.31
65-69	$ 1.96	$ 4.52	$ 13.57	$ 22.62	$ 45.23

Premium rates are based on attained age and WILL NOT CHANGE as you move to a higher age bracket.
Coverage in units of $10,000 to a maximum of $400,000. Maximum cannot exceed five times your annual salary.
Please contact the Benefit's office for more details.