



2024 HEALTH PLAN RATES

\$1200 Deductible Plan (with Dental)

Signature Care EPO

- \$30 OV Co-pay, \$15/\$40/\$60 Rx Co-pay
- 80/20 Co-insurance, Single Max OOP - \$3,700

MONTHLY RATES

Employee Only	\$69.00
Employee + Spouse Secondary*	\$97.00
Employee + 1 Primary (Spouse or Child)	\$128.00
Employee + Family without Spouse	\$138.00
Employee + Family Spouse Secondary*	\$150.00
Employee + Family Spouse Primary	\$179.00

\$3,400 Deductible Plan (with Dental)

Signature Care EPO

- 100% after deductible with exception of \$150 ER co-pay and \$40/\$60 copay on name brand Rx (after deductible has been met)

MONTHLY RATES

Employee Only	\$35.00
Employee + Spouse Secondary*	\$49.00
Employee + 1 Primary (Spouse or Child)	\$65.00
Employee + Family without Spouse	\$70.00
Employee + Family Spouse Secondary*	\$76.00
Employee + Family Spouse Primary	\$90.00

Dental Only

- \$50 Deductible, \$1,200 Annual Maximum
- 100% - Preventive
- 90% Basic
- 60% Major Services

MONTHLY RATES

Employee Only	\$12.00
Employee + 1	\$20.00
Family	\$30.00

* “Spouse Secondary” means your spouse is covered through their employer and the City's plan will be secondary. If your spouse is not covered by another plan, the City's plan will be primary.



PREMIUMS ARE DEDUCTED ON A BI-WEEKLY BASIS

To calculate premium cost per paycheck: Monthly Rate x 12 (months) ÷ 26 (pay periods)

www.cityoffortwayne.org/city-benefits

