



## 2026 COBRA Benefits

COBRA coverage requires group health plans to offer temporary continuation coverage to you and your eligible dependents (qualified beneficiaries) after a qualifying event or loss of group health coverage. This is a summary of those benefits to help you make the right decisions when you enroll.

As a COBRA participant, you have the choice to elect to keep your current benefits offerings. You may also choose to remove coverage that you have previously elected. The following benefits may be continued through COBRA — medical, dental, and vision.

	BCBS Gold Plan		BCBS Silver Plan		BCBS Bronze Plan		Kaiser Permanente*
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
<b>Annual Deductible</b>							
Individual	\$250	\$500	\$2,000	\$4,000	\$3,000	\$6,000	\$250
Family	\$750	\$1,500	\$4,000**	\$8,000	\$6,000**	\$11,000**	\$500
<b>Annual Out-Of-Pocket Maximum (Includes Deductible)</b>							
Individual	\$5,000	\$10,000	\$6,000	\$11,000	\$6,000	\$11,000	\$5,000
Family	\$10,000	\$30,000	\$11,000	\$33,000	\$11,000	\$33,000	\$10,000
<b>Copays/Coinsurance</b>							
Primary Care Physician	\$25	50%***	20%***	50%***	30%***	50%***	\$20
Specialist	\$45	50%***	20%***	50%***	30%***	50%***	\$30

\*Available to employees in the following states only: Southern California, Northern California, Mid-Atlantic States (includes Washington, D.C., Maryland, and Virginia), Colorado, Georgia, Washington, and Oregon.

\*\*For coverage types other than Employee Only, the deductible will automatically default to the family deductible.

\*\*\*Copay/cost share applies after plan deductible is met.

# Dental Plan Summary

	Cigna DPPO			DHMO
	CIGNA ADVANTAGE NETWORK	CIGNA DPPO NETWORK/ OUT-OF-AREA**	OUT-OF-NETWORK	IN-NETWORK ONLY
<b>Calendar Year Deductible</b>				
Individual	\$50	\$100	\$100	N/A
Family	\$100	\$200	\$200	N/A
<b>Annual Benefit Maximum (Excluding Orthodontia)*</b>				
Individual	\$2,000 per individual (Basic and Major Services combined)	\$1,000 per individual (Basic and Major Services combined)		N/A
<b>Services</b>				
Basic Services	10%*	20%*	20%*	Preset copays provided in Patient Charge Schedule
Major Procedures	50%*	50%*	50%*	
Orthodontia (children up to 19th birthday and adults)	50%* up to a lifetime maximum of \$2,000			

\*Cost share applies after plan deductible is met.

\*\*For employees who do not have a participating primary dentist within 25 miles of their home.

\*\*\*Out-of-network provider fees over the Plan's Reasonable and Customary (R&C) limits are your responsibility.

# Vision Plan Summary

	VSP Vision Plan	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You Pay	Reimbursement
<b>Cost</b>		
Exam	\$25	Up to \$45
<b>Covered Services — Lenses</b>		
Single Lenses	COVERED	Up to \$65 depending on lens type and option
Bifocals		
Trifocals		
Frames	Balance over \$150 allowance	Up to \$70
<b>Covered Services — Contacts in Lieu of Frames/Lenses*</b>		
Contacts — Medically Necessary	\$0	Up to \$210
Contacts — Elective	Balance over \$150 allowance	Up to \$105
<b>Benefit Frequency</b>		
Exams	Every Calendar Year	
Lenses		
Frames		
Contacts		

\*There is up to a \$60 copay for your contact lens exam (fitting and evaluation). The Vision Plan covers either lenses with frames or contact lenses, but not both. If you choose to switch to eyeglasses, they are covered 12 months from the date you obtained contact lenses.