KAIROS HEALTH ARIZONA, INC.

Osborn Elementary School District No. 8
Effective July 1, 2026 through June 30, 2027
Dual Spouse Primary

Medical and Prescription (Monthly Rates)					
Core Plan	**Employer Pays**	**You Pay**	**Total**	**COBRA**	
Individual + Spouse/Domestic Partner	$1280.00	$157.00	$1437.00	$1465.74	
Individual + Family	$1280.00	$734.00	$2014.00	$2054.28	
Copay Plan	**Employer Pays**	**You Pay**	**Total**	**COBRA**	
Individual + Spouse/Domestic Partner	$1278.00	$0.00	$1278.00	$1303.56	
Individual + Family	$1280.00	$511.00	$1791.00	$1826.82	
1,200 PPO Plan	**Employer Pays**	**You Pay**	**Total**	**COBRA**	
Individual + Spouse/Domestic Partner	$1218.00	$5.00	$1223.00	$1247.46	
Individual + Family	$1218.00	$494.00	$1712.00	$1746.24	
1,700 HDHP	**Employer Pays**	**You Pay**	**Total**	**COBRA**	**Employer HSA Contribution ***
Individual + Spouse/Domestic Partner	$1128.00	$5.00	$1133.00	$1155.66	$1800.00
Individual + Family	$1128.00	$458.00	$1586.00	$1617.72	$1800.00
2,500 HDHP	**Employer Pays**	**You Pay**	**Total**	**COBRA**	**Employer HSA Contribution ***
Individual + Spouse/Domestic Partner	$1091.00	$0.00	$1091.00	$1112.82	$2160.00
Individual + Family	$1096.00	$432.00	$1528.00	$1558.56	$2160.00
5,000 HDHP	**Employer Pays**	**You Pay**	**Total**	**COBRA**	**Employer HSA Contribution ***
Individual + Spouse/Domestic Partner	$1062.00	$2.00	$1064.00	$1085.28	$2640.00
Individual + Family	$1062.00	$428.00	$1490.00	$1519.80	$2640.00

Dental - Delta Dental (Monthly Rates)				
Dental	**Employer Pays**	**You Pay**	**Total**	**COBRA**
Individual + Spouse/Domestic Partner	$0.00	$93.00	$93.00	$94.86
Individual + Family	$0.00	$118.00	$118.00	$120.36

Prepaid Dental - EMI Health (Monthly Rates)				
Dental	**Employer Pays**	**You Pay**	**Total**	**COBRA**
Individual + Spouse/Domestic Partner	$0.00	$21.60	$21.60	$22.03
Individual + Family	$0.00	$27.00	$27.00	$27.54

Vision (Monthly Rates)				
Vision	**Employer Pays**	**You Pay**	**Total**	**COBRA**
Individual + Spouse/Domestic Partner	$0.00	$15.07	$15.07	$15.37
Individual + Family	$0.00	$25.77	$25.77	$26.29

Optional Notes: *The amount shown above is your **annual employer HSA contribution**.
See attached for all other ancillary products.

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Ancillary Rates

BENEFIT	PROVIDER	
Basic Life (Includes AD&D)	**MetLife**	
	Monthly Rates	
Employer paid	Cost Per $50,000	$5.05

BENEFIT	PROVIDER		
Supplemental Life (Includes AD&D)	**MetLife**		
	Monthly Rates		
Age	Cost per $1,000	Age	Cost per $1,000
Under age 30	$0.067	50-54	$0.225
30-34	$0.086	55-59	$0.411
35-39	$0.095	60-64	$0.625
40-44	$0.119	65-69	$1.192
45-49	$0.151	70+	$2.470
Child	$0.152		

BENEFIT	PROVIDER
Short Term Disability	**MetLife**
	Monthly Rates
Age	Per $10 weekly benefit
<45	$0.345
45-49	$0.424
50-54	$0.530
55-59	$0.645
60-64	$0.769
65+	$0.919

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BENEFIT	PROVIDER
Worksite Benefits (Hospital Indemnity)	**MetLife**

Monthly Rates

Employee:	$14.60
Employee + Spouse:	$26.96
Employee + Child(ren):	$22.76
Family:	$35.12

BENEFIT	PROVIDER
Worksite Benefits (Critical Illness)	**MetLife**

Monthly Premium for $1,000 of Coverage

Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse/Children
<25	$0.20	$0.34	$0.20	$0.34
25-29	$0.21	$0.37	$0.21	$0.37
30-34	$0.30	$0.51	$0.30	$0.51
35-39	$0.42	$0.71	$0.42	$0.71
40-44	$0.64	$1.06	$0.64	$1.06
45-49	$0.95	$1.58	$0.95	$1.58
50-54	$1.35	$2.27	$1.35	$2.27
55-59	$1.87	$3.17	$1.87	$3.17
60-64	$2.69	$4.60	$2.69	$4.60
65-69	$4.03	$6.90	$4.03	$6.90
70+	$6.25	$10.46	$6.25	$10.46

BENEFIT	PROVIDER
Worksite Benefits (Accident)	**MetLife**

Monthly Rates

Employee:	$12.48
Employee + Spouse:	$25.34
Employee + Child(ren):	$25.81
Family:	$32.31

Upon selection, a more comprehensive overview of the benefits will be provided. If you have any questions, please contact your member advocate at 888.331.0222.