CITY OF DUVALL

Employee Benefits 2026

NON-REPRESENTED EMPLOYEES

City of Duvall
Small Town. Real Life.

Benefit Options

MEDICAL PLANS

- REGENCE $250 DEDUCTIBLE PLAN
- KAISER PERMANENTE $200 DEDUCTIBLE PLAN

DENTAL PLANS

- DELTA DENTAL (PLAN E) W/ ORTHODONTIA (PLAN II) - $0 TO $5.16/MONTH DEPENDING ON FAMILY SIZE
- WILLAMETTE DENTAL - $10 COPAY PLAN - 100% EMPLOYEE/SPOUSE/DEPENDENTS COVERAGE PAID BY THE CITY

VISION SERVICES PLAN (VSP) - $0 COPAY PLAN - 100% EMPLOYEE/SPOUSE/DEPENDENTS COVERAGE PAID BY THE CITY

Other Perks

- LIFE & LONG TERM DISABILITY INSURANCES
- OPTIONAL 457 DEFERRED COMPENSATION PLAN WITH MATCHING CONTRIBUTIONS (UP TO $100/MONTH)
- EMPLOYEE ASSISTANCE PROGRAM (EAP)
- WELLNESS PROGRAM
- 11 PAID HOLIDAYS & 2 FLOATING HOLIDAYS
- THE CITY'S COMMITMENT TO GROWTH & DEVELOPMENT OF EMPLOYEES MAY INCLUDE TUITION REIMBURSEMENT, CERTIFICATIONS AND LICENSES, CONFERENCES, AND MORE
- THE CITY IS A MEMBER OF THE SOCIAL SECURITY SYSTEM
- WORK FROM HOME OPTIONS FOR ELIGIBLE POSITIONS

MEDICAL PLAN HIGHLIGHTS

	REGENCE $250 DEDUCTIBLE PLAN PREFERRED PROVIDERS	KAISER PERMANENTE $200 DEDUCTIBLE PLAN
Calendar Year Deductible (Per Person/Per Family)	$250/$750 per calendar year	$200/$400 per calendar year
Out-of-Pocket Maximum (Per Person/Per Family)	$3,000/$6,000 per calendar year	$2,500/$5,000 per calendar year
Preventative Care	No charge, deductible does not apply	No charge, deductible does not apply
Professional Office Visit (Primary Care or Specialist)	10% coinsurance - Deductible does not apply to the first 4 preferred or participating provider office visits / year (combined with urgent care and mental health/substance)	Primary Care - $20 Copay + 10% Coinsurance (does not apply to first 4 visits per calendar year) Specialist Visit - $20 Copay + 10% Coinsurance
Spinal Manipulations	20 visits per calendar year	20 visits per calendar year
Outpatient Surgery	10% coinsurance (Facility Fee & Physician/Surgeon Fees)	Facility Fee - $20 Copay + 10% Coinsurance Physician/Surgeon Fees - 10% Coinsurance
Diagnostic Services (X-rays, blood work)	10% coinsurance	No charge up to $500 allowance per calendar year (combined with imaging), then 10% Coinsurance

MEDICAL PLAN HIGHLIGHTS

	REGENCE $250 DEDUCTIBLE PLAN PREFERRED PROVIDERS	KAISER PERMANENTE $200 DEDUCTIBLE PLAN
Imaging Services (MRI, CT, Pet Scans)	10% coinsurance	No charge up to $500 allowance per calendar year (combined with diagnostic), then 10% Coinsurance
Emergency Care	ER - 10% coinsurance after $75 copay per visit Emergency Transportation - 20% coinsurance Urgent Care - 10% coinsurance - Deductible does not apply to the first 4 preferred or participating provider office visits / year (combined with urgent care and mental health/substance)	ER - $75 Copay + 10% Coinsurance Emergency Transportation - 20% Coinsurance - Deductible does not apply Urgent Care - $20 Copay + 10% Coinsurance
Hospital Inpatient Care (Room & Board, Intensive Care, etc.)	Outpatient - 10% coinsurance - Deductible does not apply to the first 4 preferred or participating provider office visits / year (combined with urgent care and mental health/substance) Inpatient - 10% coinsurance	10% Coinsurance (Facility Fee & Physician/Surgeon Fee)
Mental Health, Behavioral Health, & Substance Abuse Services	Outpatient - 10% coinsurance - Deductible does not apply to the first 4 preferred or participating provider office visits / year (combined with urgent care and mental health/substance) Inpatient - 10% coinsurance	Outpatient - $20 Copay + 10% Coinsurance Inpatient 10% Coinsurance

MEDICAL PLAN HIGHLIGHTS

	REGENCE $250 DEDUCTIBLE PLAN PREFERRED PROVIDERS	KAISER PERMANENTE $200 DEDUCTIBLE PLAN
Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy, etc.)	10% coinsurance Inpatient - 15 days/year Outpatient - 99 visits/year	Outpatient - $20 Copay + 10% Coinsurance (up to 60 visits per year) Inpatient 10% Coinsurance (up to 60 visits per year)
Prescription Drugs	Tier 1 - (retail/home delivery) $5 copay/$10 copay Tier 2 - (retail/home delivery) $25 copay/$50 copay Tier 3 - (retail/home delivery) $50 copay/$100 copay Tier 4 - (Specialty) $100 Home Delivery - 90 Day Supply More information about prescription drug coverage is available at https://regence.com/go/2025/WW/4tierLG	Preferred Generic - $10 Copay Preferred Brand - $20 Copay Non-Preferred - $40 Copay *Copayment per 30-days up to a 90-day supply Specialty - Applicable Preferred Generic, Preferrd Brand, or Non-Preferred cost shares. Up to a 30-day retail supply

DENTAL PLAN HIGHLIGHTS

	DELTA DENTAL (PLAN E) W/ ORTHO RIDER (PLAN II)	WILLAMETTE DENTAL
Preventative Class I	Incentive Level Plan 70% - 100%	$10 Copay
Class II	Incentive Level Plan 70% - 100%	$10 Copay
Class III	50%	$10 Copay
Orthodontia	$1,000 Lifetime Maximum per Person	$150 Pre-Treatment Copay $1,000 Treatment Copay
Deductible	None	None
Annual Plan Maximum	$2,000	None

VISION PLAN HIGHLIGHTS

VISION SERVICE PLAN

	Description	Copay	Frequency
Exam		None	Every 12 Months
Presciption Glasses & Frames	$220 featured frame brands allowance $200 frame allowance 20% savings on the amount over your allowance $120 Walmart®/Sam's Club®/Costco® frame allowance	None	Every 24 Months
Lenses	Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses	None	Every 12 Months
Contacts (instead of glasses)	$200 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation)	None	Every 24 Months

2026 RATES

2026 MEDICAL MONTHLY PREMIUM RATES

	Regence $250 Deductible			Kaiser Permanente $200 Deductible		
	Employer Cost	Employee Cost **	Total	Employer Cost	Employee Cost **	Total
Employee	$1,037.70	$0.00	$1,037.70	$952.38	$0.00	$952.38
Employee/Spouse	$1,927.10	$156.96	$2,084.06	$1,748.46	$140.50	$1,888.96
Employee/Spouse/ Child	$2,365.22	$234.28	$2,599.50	$2,154.68	$212.18	$2,366.86
Employee/Spouse/ 2 or more Children	$2,727.44	$298.20	$3,025.64	$2,560.90	$283.86	$2,844.76
Employee/Child	$1,475.82	$77.32	$1,553.14	$1,358.60	$71.70	$1,430.30
Employee/2 or more Children	$1,838.04	$141.24	$1,979.28	$1,764.82	$143.38	$1,908.20

** THE CITY PAYS 100% OF EMPLOYEE & 85% OF SPOUSE/DEPENDENT MEDICAL COVERAGE; EMPLOYEE PORTION IS DEDUCTED ½ ON FIRST CHECK & ½ ON THE SECOND CHECK OF THE MONTH

2026 RATES

2026 DENTAL MONTHLY PREMIUM RATES

Delta Dental Plan E with Ortho Rider Plan II

	Employer Cost	Employee Cost	Total
Employee	$51.78	$0.00	$51.78
Employee/Spouse	$96.58	$0.12	$96.70
Employee/Spouse/Child	$173.72	$5.16	$178.88
Employee/Spouse/2 or more Children	$173.72	$5.16	$178.88
Employee/Child	$96.58	$0.12	$96.70
Employee/2 or more Children	$173.72	$5.16	$178.88

Willamette Dental

	Employer Cost	Employee Cost	Total
Employee	$74.00	$0.00	$74.00
Employee/Spouse	$138.64	$0.00	$138.64
Employee/Spouse/Child	$220.80	$0.00	$220.80
Employee/Spouse/2 or more Children	$220.80	$0.00	$220.80
Employee/Child	$138.64	$0.00	$138.64
Employee/2 or more Children	$220.80	$0.00	$220.80

2026 RATES

2026 VISION MONTHLY PREMIUM RATES

Vision Services Plan

	Employer Cost	Employee Cost	Total
Employee	$10.96	$0.00	$10.96
Employee/Spouse	$21.92	$0.00	$21.92
Employee/Spouse/Child	$32.88	$0.00	$32.88
Employee/Spouse/2 or more Children	$32.88	$0.00	$32.88
Employee/Child	$21.92	$0.00	$21.92
Employee/2 or more Children	$32.88	$0.00	$32.88

QUESTIONS ??

CONTACT FINANCE DEPT

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