CITY OF LOWELL

FY2026 MEDICAL AND DENTAL RATES

Plan Name	Coverage	Monthly Premium (100%)	21 Weeks (25%)	26 Weeks (25%)	Monthly (25%)	COBRA
Harvard Pilgrim Access America (PPO)	Individual	$1,438.62	$205.52	$165.99	$359.66	$1467.39
	Family	$3,208.78	$458.40	$370.24	$802.20	$3,272.96
Harvard Pilgrim Explorer (POS)	Individual	$1,187.97	$169.71	$137.07	$296.99	$1,211.73
	Family	$2,941.06	$420.15	$339.35	$735.27	$2,999.88
Harvard Pilgrim Quality (HMO)	Individual	$885.63	$126.52	$102.19	$221.41	$903.34
	Family	$2,252.51	$321.79	$259.91	$563.13	$2,297.56
Mass General Brigham Health Plan Complete (HMO)	Individual	$1,091.46	$155.92	$125.94	$272.87	$1,113.29
	Family	$2,884.58	$412.08	$332.84	$721.15	$2,9242.27
Health New England (HMO)	Individual	$859.36	$122.77	$99.16	$214.84	$876.55
	Family	$2,061.16	$294.45	$237.83	$515.29	$2,102.38
Wellpoint Total Choice (Indemnity)	Individual	$1,754.60	$250.66	$202.45	$438.65	$1,789.69
	Family	$3,899.83	$557.12	$449.98	$974.96	$3,977.83
Wellpoint PLUS (PPO-Type)	Individual	$1,092.03	$156.00	$126.00	$273.01	$1,113.87
	Family	$2,606.03	$372.29	$300.70	$651.51	$2,658.15
Wellpoint Community Choice (PPO-Type)	Individual	$837.38	$119.63	$96.62	$209.35	$854.13
	Family	$2,081.29	$297.33	$240.15	$520.32	$2,122.92

CITY OF LOWELL

FY2026 MEDICAL AND DENTAL RATES

GIC Medicare Plans

Plan Name	Coverage	Monthly Premium (100%)	Bi-Weekly (25%)	Monthly (25%)
Tufts Health Plan Medicare Preferred (HMO)	Individual	$391.19	$45.14	$97.80
Harvard Pilgrim Medicare Enhance (Indemnity)	Individual	$468.22	$54.03	$117.06
Health New England Medicare Supplement Plus (Indemnity)	Individual	$470.71	$54.31	$117.68
Wellpoint Medicare Extension (Indemnity)	Individual	$476.33	$54.96	$119.08

Delta Dental Plans

Plan Name	Coverage	Monthly Premium (100%)	21 Weeks (25%)	26 Weeks (25%)	Monthly (25%)	COBRA
Low Option	Individual	$23.46	$3.35	$2.71	$5.87	$23.93
	Family	$63.81	$9.12	$7.36	$15.95	$65.09
High Option	Individual	$38.58	$13.75	$11.10	$24.06	$39.35
	Family	$105.57	$37.62	$30.38	$65.83	$107.68

Vision Plan

EyeMed Vision	Coverage	Monthly Premium (100%)	21 Weeks	26 Weeks	COBRA
	Individual	$6.13	$3.50	$2.83	$6.25
	Family	$16.92	$9.67	$7.81	$17.26