

2026 Rate Chart For Active Employees**Budgeted Positions at more than 20 hours per week**

This Chart applies to all Employees whose positions are represented by any of the following units:

**GC Management; DC #48; NMNR; TEAM; Assc of Scient Pers; Assc of Muni Attys;
SNC; Loc 510 IAM; Loc 494 Mach; Loc 75 Plumbers; Loc 195 Bridge Operators; Loc 139;
Loc 61 Sanitation; ALEASP; Police Aides; Loc 494 FEDS; Loc 494 Electrical; MBCTC; City Laborers**

EMPLOYEE RATE INFORMATION

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.
In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 381.88	\$ 52.08	\$ 104.16	\$ 509.73	\$ 381.88	\$ 127.85	\$ 255.70
Employee + Spouse	\$ 867.91	\$ 763.76	\$ 104.15	\$ 208.30	\$ 1,021.57	\$ 763.76	\$ 257.81	\$ 515.62
Employee + Child(ren)	\$ 650.14	\$ 572.12	\$ 78.02	\$ 156.04	\$ 766.18	\$ 572.12	\$ 194.06	\$ 388.12
Family	\$ 1,300.28	\$ 1,144.25	\$ 156.03	\$ 312.06	\$ 1,531.30	\$ 1,144.25	\$ 387.05	\$ 774.10

2026 Employee DENTAL PLAN Payroll Contribution.

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 13.93	\$ 6.50	\$ 7.43	\$ 14.86	\$ 48.12	\$ 18.75	\$ 29.37	\$ 58.74
Delta Dental EPO	\$ 24.83	\$ 6.50	\$ 18.33	\$ 36.66	\$ 81.13	\$ 18.75	\$ 62.38	\$ 124.76
Care-Plus	\$ 26.78	\$ 6.50	\$ 20.28	\$ 40.56	\$ 78.89	\$ 18.75	\$ 60.14	\$ 120.28

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

ACA NOTICE: The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

2026 RATE CHART FOR ACTIVE AGENCY EMPLOYEES

This Chart applies to all Employees whose positions are represented by any of the following units:

HACM, MEDC & WCD EMPLOYEES**EMPLOYEE RATE INFORMATION**

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.
In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 381.88	\$ 52.08	\$ 104.16	\$ 509.73	\$ 381.88	\$ 127.85	\$ 255.70
Employee + Spouse	\$ 867.91	\$ 763.76	\$ 104.15	\$ 208.30	\$ 1,021.57	\$ 763.76	\$ 257.81	\$ 515.62
Employee + Child(ren)	\$ 650.14	\$ 572.12	\$ 78.02	\$ 156.04	\$ 766.18	\$ 572.12	\$ 194.06	\$ 388.12
Family	\$ 1,300.28	\$ 1,144.25	\$ 156.03	\$ 312.06	\$ 1,531.30	\$ 1,144.25	\$ 387.05	\$ 774.10

2026 Employee DENTAL PLAN Payroll Contribution.

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 13.93	\$ 6.50	\$ 7.43	\$ 14.86	\$ 48.12	\$ 18.75	\$ 29.37	\$ 58.74
Delta Dental EPO	\$ 24.83	\$ 6.50	\$ 18.33	\$ 36.66	\$ 81.13	\$ 18.75	\$ 62.38	\$ 124.76
Care-Plus	\$ 26.78	\$ 6.50	\$ 20.28	\$ 40.56	\$ 78.89	\$ 18.75	\$ 60.14	\$ 120.28

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.**ACA NOTICE:** The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

2026 Rate Chart For Active Employees

This Chart applies to all Employees whose positions are represented by any of the following units:

Milwaukee Professional Fire Fighters' Assc - Loc 215; Sworn Fire Management**EMPLOYEE RATE INFORMATION***

*(Rate subject to change in negotiations)

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.

In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 381.88	\$ 52.08	\$ 104.16	\$ 509.73	\$ 381.88	\$ 127.85	\$ 255.70
Employee + Spouse	\$ 867.91	\$ 763.76	\$ 104.15	\$ 208.30	\$ 1,021.57	\$ 763.76	\$ 257.81	\$ 515.62
Employee + Child(ren)	\$ 650.14	\$ 572.12	\$ 78.02	\$ 156.04	\$ 766.18	\$ 572.12	\$ 194.06	\$ 388.12
Family	\$ 1,300.28	\$ 1,144.25	\$ 156.03	\$ 312.06	\$ 1,531.30	\$ 1,144.25	\$ 387.05	\$ 774.10

2026 Employee DENTAL PLAN Payroll Contribution.

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 16.71	\$ 6.50	\$ 10.21	\$ 20.42	\$ 47.86	\$ 18.75	\$ 29.11	\$ 58.22
Delta Dental EPO	\$ 24.83	\$ 6.50	\$ 18.33	\$ 36.66	\$ 81.13	\$ 18.75	\$ 62.38	\$ 124.76
Care-Plus	\$ 26.78	\$ 6.50	\$ 20.28	\$ 40.56	\$ 78.89	\$ 18.75	\$ 60.14	\$ 120.28

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

ACA NOTICE: The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

2026 Rate Chart For Active Employees

This Chart applies to all Employees whose positions are represented by any of the following units:

Milwaukee Police Association (MPA)**MPA EMPLOYEE RATE INFORMATION***

***(Rate subject to change in negotiations)**

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.

In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 381.88	\$ 52.08	\$ 104.16	\$ 509.73	\$ 381.88	\$ 127.85	\$ 255.70
Employee + Spouse	\$ 867.91	\$ 763.76	\$ 104.15	\$ 208.30	\$ 1,021.57	\$ 763.76	\$ 257.81	\$ 515.62
Employee + Child(ren)	\$ 650.14	\$ 572.12	\$ 78.02	\$ 156.04	\$ 766.18	\$ 572.12	\$ 194.06	\$ 388.12
Family	\$ 1,300.28	\$ 1,144.25	\$ 156.03	\$ 312.06	\$ 1,531.30	\$ 1,144.25	\$ 387.05	\$ 774.10

2026 Employee DENTAL PLAN Payroll Contribution.

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 16.76	\$ 6.50	\$ 10.26	\$ 20.52	\$ 50.98	\$ 18.75	\$ 32.23	\$ 64.46
Delta Dental EPO	\$ 24.83	\$ 6.50	\$ 18.33	\$ 36.66	\$ 81.13	\$ 18.75	\$ 62.38	\$ 124.76
Care-Plus	\$ 26.78	\$ 6.50	\$ 20.28	\$ 40.56	\$ 78.89	\$ 18.75	\$ 60.14	\$ 120.28

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

ACA NOTICE: The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

2026 Rate Chart For Active Employees

This Chart applies to all Employees whose positions are represented by any of the following units:

Police Sworn Management (PSM) and Milwaukee Police Supervisors Organization (MPSO)

EMPLOYEE RATE INFORMATION*

*(Rate subject to change in negotiations)

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.

In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 381.88	\$ 52.08	\$ 104.16	\$ 509.73	\$ 381.88	\$ 127.85	\$ 255.70
Employee + Spouse	\$ 867.91	\$ 763.76	\$ 104.15	\$ 208.30	\$ 1,021.57	\$ 763.76	\$ 257.81	\$ 515.62
Employee + Child(ren)	\$ 650.14	\$ 572.12	\$ 78.02	\$ 156.04	\$ 766.18	\$ 572.12	\$ 194.06	\$ 388.12
Family	\$ 1,300.28	\$ 1,144.25	\$ 156.03	\$ 312.06	\$ 1,531.30	\$ 1,144.25	\$ 387.05	\$ 774.10

2026 Employee DENTAL PLAN Payroll Contribution.

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 16.76	\$ 6.50	\$ 10.26	\$ 20.52	\$ 50.98	\$ 18.75	\$ 32.23	\$ 64.46
Delta Dental EPO	\$ 24.83	\$ 6.50	\$ 18.33	\$ 36.66	\$ 81.13	\$ 18.75	\$ 62.38	\$ 124.76
Care-Plus	\$ 26.78	\$ 6.50	\$ 20.28	\$ 40.56	\$ 78.89	\$ 18.75	\$ 60.14	\$ 120.28

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

ACA NOTICE: The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

2026 RATE CHART FOR ACTIVE LBE EMPLOYEES**Limited Benefit Employees (LBE) = Budgeted Positions at Half Time (20 hours per week)**

This Chart applies to all employees whose positions are represented by any of the following units:

**GC Management; NMNR; ALEASP (Clerical); Police Service Specialist (ALEASP); DC #48; MBCTC;
TEAM; Assc of Scient Pers; Assc of Muni Atty; SNC; Loc 139; Loc 61 Sanitation;
Loc 195 Bridge Operators; Loc 78 Plumbers; Loc 494 Mach Shop; Loc 510 IAM; Loc 494 Electrical**

(Seasonal employees are not eligible for City dental coverage)

HEALTH PLAN "LBE EMPLOYEE RATE" COMPUTATION

For 2026, the City will contribute 75% of the Single Premium and 60% of the Family Premium of the lowest cost plan, excludes HDHP.

EMPLOYEE RATE INFORMATION

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.

In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 LBE Employee HEALTH PLAN Payroll Contribution.

HEALTH PLAN	UHC CHOICE PLAN (EPO)				UHC CHOICE PLUS PLAN (PPO)			
	UHC Premium Bi-Weekly	Single Required City Contribution	Employee Bi-Weekly Rate	Employee Monthly Rate	UHC Premium Bi-Weekly	Family Required City Contribution	Employee Bi-Weekly Rate	Employee Monthly Rate
Single	\$ 433.96	\$ 325.47	\$ 108.49	\$ 216.98	\$ 509.73	\$ 325.47	\$ 184.26	\$ 368.52
Employee + Spouse	\$ 867.91	\$ 520.75	\$ 347.16	\$ 694.32	\$ 1,021.57	\$ 520.75	\$ 500.82	\$ 1,001.64
Employee + Child(ren)	\$ 650.14	\$ 390.08	\$ 260.06	\$ 520.12	\$ 766.18	\$ 390.08	\$ 376.10	\$ 752.20
Family	\$ 1,300.28	\$ 780.17	\$ 520.11	\$ 1,040.22	\$ 1,531.30	\$ 780.17	\$ 751.13	\$ 1,502.26

2026 LBE Employee DENTAL Plan Payroll Contribution

DENTAL PLAN	SINGLE PREMIUM Bi-Weekly	City Share Bi-Weekly	Single Employee Bi-Weekly Rate	Single Employee Monthly Rate	FAMILY PREMIUM Bi-Weekly	City Share Bi-Weekly	Family Employee Bi-Weekly Rate	Family Employee Monthly Rate
Delta Dental PPO	\$ 13.93	\$ 3.25	\$ 10.68	\$ 21.36	\$ 48.12	\$ 9.38	\$ 38.74	\$ 77.48
Delta Dental EPO	\$ 24.83	\$ 3.25	\$ 21.58	\$ 43.16	\$ 81.13	\$ 9.38	\$ 71.75	\$ 143.50
Care-Plus	\$ 26.78	\$ 3.25	\$ 23.53	\$ 47.06	\$ 78.89	\$ 9.38	\$ 69.51	\$ 139.02

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

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City of Milwaukee
DER/Employee Benefits Division
Full Premium Rates (100%)

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 867.91	\$ 1,019.45
Employee + Spouse	\$ 1,735.82	\$ 2,043.14
Employee + Child(ren)	\$ 1,300.28	\$ 1,532.35
Family	\$ 2,600.55	\$ 3,062.59
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 27.86	\$ 96.24
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

City of Milwaukee - GENERAL CITY
DER/Employee Benefits Division
Rates include a 2% Admin Fee

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 885.27	\$ 1,039.84
Employee + Spouse	\$ 1,770.54	\$ 2,084.00
Employee + Child(ren)	\$ 1,326.29	\$ 1,563.00
Family	\$ 2,652.56	\$ 3,123.84
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 28.42	\$ 98.16
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

City of Milwaukee - GENERAL CITY
DER/Employee Benefits Division
Disability Retirees

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 1,301.87	\$ 1,529.18
Employee + Spouse	\$ 2,603.73	\$ 3,064.71
Employee + Child(ren)	\$ 1,950.42	\$ 2,298.53
Family	\$ 3,900.83	\$ 4,593.89
Rates Include a 50% Admin Fee		
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 41.79	\$ 144.36
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates Include a 50% Admin Fee		

**City of Milwaukee - GENERAL CITY
COBRA DISABILITY EXTENSION RATES**

2026 COBRA HEALTH DISABILITY EXTENSION RATES

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 1,301.87	\$ 1,529.18
Employee + Spouse	\$ 2,603.73	\$ 3,064.71
Employee + Child(ren)	\$ 1,950.42	\$ 2,298.53
Family	\$ 3,900.83	\$ 4,593.89
Rates Include a 50% Admin Fee		
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 41.79	\$ 144.36
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates Include a 50% Admin Fee		

If you have questions, please call our office at (414) 286-3184 and your question(s) will be directed to the appropriate person.

City of Milwaukee - POLICE
DER/Employee Benefits Division
Full Premium Rates (100%)

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 867.91	\$ 1,019.45
Employee + Spouse	\$ 1,735.82	\$ 2,043.14
Employee + Child(ren)	\$ 1,300.28	\$ 1,532.35
Family	\$ 2,600.55	\$ 3,062.59
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 33.52	\$ 101.96
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

City of Milwaukee - POLICE
DER/Employee Benefits Division
Rates include a 2% Admin Fee

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 885.27	\$ 1,039.84
Employee + Spouse	\$ 1,770.54	\$ 2,084.00
Employee + Child(ren)	\$ 1,326.29	\$ 1,563.00
Family	\$ 2,652.56	\$ 3,123.84
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 34.19	\$ 104.00
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

POLICE COBRA DISABILITY EXTENSION RATES

2026 COBRA HEALTH DISABILITY EXTENSION RATES

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 1,301.87	\$ 1,529.18
Employee + Spouse	\$ 2,603.73	\$ 3,064.71
Employee + Child(ren)	\$ 1,950.42	\$ 2,298.53
Family	\$ 3,900.83	\$ 4,593.89
Rates include a 50% Admin Fee		
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 50.28	\$ 152.94
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates include a 50% Admin Fee		

If you have questions, please call our office at (414) 286-3184 and your question(s) will be directed to the appropriate person.

**City of Milwaukee - FIRE
DER/Employee Benefits Division
Full Premium Rates (100%)**

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 867.91	\$ 1,019.45
Employee + Spouse	\$ 1,735.82	\$ 2,043.14
Employee + Child(ren)	\$ 1,300.28	\$ 1,532.35
Family	\$ 2,600.55	\$ 3,062.59
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 33.42	\$ 95.72
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

**City of Milwaukee - FIRE
DER/Employee Benefits Division
Rates include a 2% Admin Fee**

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 885.27	\$ 1,039.84
Employee + Spouse	\$ 1,770.54	\$ 2,084.00
Employee + Child(ren)	\$ 1,326.29	\$ 1,563.00
Family	\$ 2,652.56	\$ 3,123.84
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 34.09	\$ 97.63
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

FIRE COBRA DISABILITY EXTENSION RATES 2026 COBRA HEALTH DISABILITY EXTENSION RATES

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC Choice Rate (EPO)	UHC Choice Plus Rate (PPO)
Single	\$ 1,301.87	\$ 1,529.18
Employee + Spouse	\$ 2,603.73	\$ 3,064.71
Employee + Child(ren)	\$ 1,950.42	\$ 2,298.53
Family	\$ 3,900.83	\$ 4,593.89
Rates include a 50% Admin Fee		
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 50.13	\$ 143.58
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates include a 50% Admin Fee		

If you have questions, please call our office at (414) 286-3184 and your question(s) will be directed to the appropriate person.

2026 Rate Chart For High Deductible Health Plan (HDHP)

This Chart applies to all Employees whose positions are represented by any of the following units:

MPA, MPSO, SWORN POLICE MGT, LOCAL 215, SWORN FIRE MGT
ALL ACTIVE FULL TIME CITY EMPLOYEES (Excludes HACM, MEDC and WCD)

EMPLOYEE RATE INFORMATION

An employee's deduction, listed below "Employee Bi-Weekly Rate" for the plan selected, will be taken twice a month.
 In the months where there are 3 paychecks, no deduction is taken on the 3rd check of the month.

2026 Employee HIGH DEDUCTIBLE HEALTH PLAN Payroll Contribution.

HEALTH PLAN	High Deductible Health Plan (HDHP)				
	UHC Premium Bi-Weekly	City Share Bi-Weekly	Employee Bi-Weekly Rate	Employee Monthly Rate	
Single	\$ 420.71	\$ 370.22	\$ 50.49	\$ 100.97	The City's High Deductible Health Plan (HDHP) has a benefit design and coverage that is VERY DIFFERENT from the UHC Choice and Choice Plus plans. Although the premium is slightly lower, please review the differences below carefully before selecting this plan. See the Benefits Guide for more details.
Employee + Spouse	\$ 840.36	\$ 739.52	\$ 100.84	\$ 201.69	
Employee + Child(ren)	\$ 631.07	\$ 555.34	\$ 75.73	\$ 151.46	
Family	\$ 1,262.13	\$ 1,110.67	\$ 151.46	\$ 302.91	

In-Network providers: Only in-network providers are covered under this plan.

Combined Deductible: There is a \$2,000/\$4,000 single/family combined deductible for medical and prescription drugs. One person in a family plan may be responsible for the entire \$4,000 family deductible.

Co-Insurance: There is a 80% co-insurance for Tier 1 Premium providers and a 60% co-insurance for non-Tier 1 Premium providers. There is no limit to the per person co-insurance limit and one person in a family plan may be responsible for the \$4,000 co-insurance before meeting the Out of Pocket Maximum.

Out of Pocket Maximum (OOPM): There is a \$4,000/\$8,000 single/family combined medical and prescription drug OOPM. One person in a family plan may be responsible for the entire \$8,000 family OOPM.

Prescription Drugs: Members pay 100% for prescription drugs with combined medical/prescription drug deductible and then 20% co-insurance until the OOPM \$4,000/\$8,000 is met. There are no minimum/maximum costs for prescription drugs.

Emergency Room: Members pay 100% for emergency room services until the full single/family deductible is met and then pays a 20% coinsurance until the \$4,000/\$8,000 OOPM is met.

DISCLAIMER: The benefit design and rate equivalents are subject to change by Common Council action.

ACA NOTICE: The individual shared responsibility provision of the Affordable Care Act requires you and each member of your family to have qualifying health care coverage (called minimum essential coverage), qualify for a coverage exemption, or make an individual shared responsibility payment when you file your federal income tax return.

City of Milwaukee
DER/Employee Benefits Division
Full Premium Rates (100%)

2026 COBRA HEALTH PREMIUM RATES		
HEALTH	UHC High Deductible Health Plan (HDHP)	
Single	\$	841.42
Employee + Spouse	\$	1,680.72
Employee + Child(ren)	\$	1,262.13
Family	\$	2,524.25
2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 27.86	\$ 96.24
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

2026 COBRA DENTAL PREMIUM RATES - POLICE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 33.52	\$ 101.96
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

2026 COBRA DENTAL PREMIUM RATES - FIRE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 33.42	\$ 95.72
Delta Dental EPO	\$ 49.66	\$ 162.26
Care-Plus	\$ 53.55	\$ 157.78

City of Milwaukee
DER/Employee Benefits Division
Rates include a 2% Admin Fee

2026 COBRA HEALTH PREMIUM RATES	
HEALTH	UHC High Deductible Health Plan (HDHP)
Single	\$ 858.25
Employee + Spouse	\$ 1,714.33
Employee + Child(ren)	\$ 1,287.37
Family	\$ 2,574.74

2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 28.42	\$ 98.16
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

2026 COBRA DENTAL PREMIUM RATES - POLICE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 34.19	\$ 104.00
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

2026 COBRA DENTAL PREMIUM RATES - FIRE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 34.09	\$ 97.63
Delta Dental EPO	\$ 50.65	\$ 165.51
Care-Plus	\$ 54.62	\$ 160.94

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COBRA DISABILITY EXTENSION RATES

2026 COBRA HEALTH DISABILITY EXTENSION RATES

2026 COBRA HEALTH PREMIUM RATES	
HEALTH	UHC High Deductible Health Plan (HDHP)
Single	\$ 1,262.13
Employee + Spouse	\$ 2,521.08
Employee + Child(ren)	\$ 1,893.20
Family	\$ 3,786.38
Rates Include a 50% Admin Fee	

2026 COBRA DENTAL PREMIUM RATES		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 41.79	\$ 144.36
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates Include a 50% Admin Fee		

2026 COBRA DENTAL PREMIUM RATES - POLICE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 50.28	\$ 152.94
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates Include a 50% Admin Fee		

2026 COBRA DENTAL PREMIUM RATES - FIRE		
DENTAL PLAN	SINGLE PREMIUM	FAMILY PREMIUM
Delta Dental PPO	\$ 50.13	\$ 143.58
Delta Dental EPO	\$ 74.49	\$ 243.39
Care-Plus	\$ 80.33	\$ 236.67
Rates Include a 50% Admin Fee		

If you have questions, please call our office at (414) 286-3184 and your question(s) will be directed to the appropriate person.

2026 Rate Chart For Active Employees**Budgeted Positions at more than 20 hours per week**

This Chart applies to all Employees whose positions are represented by any of the following units:

ALL ACTIVE CITY EMPLOYEES
Excludes Agencies: HACM, MEDC, WCD

An employee's deduction will be taken monthly on the first paycheck of the month.

2026 Employee VISION PLAN Payroll Contribution.

VISION PLAN MET LIFE	Employee Monthly Rate
Single	\$ 7.82
Employee + Spouse	\$ 16.29
Employee + Child(ren)	\$ 13.79
Family	\$ 22.73

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Rates include a 2% Admin Fee

2026 COBRA VISION PREMIUM RATES		
Single	\$	7.98
Employee + Spouse	\$	16.62
Employee + Child(ren)	\$	14.07
Family	\$	23.18

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COBRA DISABILITY EXTENSION RATES

2026 COBRA VISION PREMIUM RATES		
Single	\$	11.73
Employee + Spouse	\$	24.44
Employee + Child(ren)	\$	20.69
Family	\$	34.10
Rates Include a 50% Admin Fee		