

**COUNTY OF LOS ALAMOS
GROUP INSURANCE RATES
2026**

DEDUCTIBLES OF \$350 FOR INDIVIDUAL AND \$700 FOR FAMILY

MEDICAL INSURANCE - BLUE CROSS/BLUE SHIELD NEW MEXICO - BLUE PPO 35

Office visit co-pay/Specialist Co-pay \$35/\$50
Prescription drug co-pay \$15/\$35/\$55
Deductibles - Individual/Family \$350/\$700

	Total Premium		Full-Time Employee		3/4-Time Employee		1/2-Time Employee	
			Per Pay Period		Per Pay Period		Per Pay Period	
	Per Month	Per Pay Period	County 80%	Participant 20%	County 60%	Participant 40%	County 40%	Participant 60%
Employee only	\$861.23	\$430.61	\$344.49	\$86.12	\$258.37	\$172.25	\$172.25	\$258.37
Employee + one	\$1,636.25	\$818.12	\$654.50	\$163.62	\$490.87	\$327.25	\$327.25	\$490.87
Employee + two or more	\$2,497.46	\$1,248.73	\$998.99	\$249.75	\$749.24	\$499.49	\$499.49	\$749.24

MEDICAL INSURANCE - BLUE CROSS BLUE SHIELD of NEW MEXICO - BLUE PPO 45

Office visit co-pay/Specialist Co-pay \$45/\$60
Prescription drug co-pay \$15/\$35/\$55
Deductibles - Individual/Family \$350/\$700

	Total Premium		Full-Time Employee		3/4-Time Employee		1/2-Time Employee	
			Per Pay Period		Per Pay Period		Per Pay Period	
	Per Month	Per Pay Period	County 80%	Participant 20%	County 60%	Participant 40%	County 40%	Participant 60%
Employee only	\$747.53	\$373.77	\$299.01	\$74.75	\$224.26	\$149.51	\$149.51	\$224.26
Employee + one	\$1,420.34	\$710.17	\$568.14	\$142.03	\$426.10	\$284.07	\$284.07	\$426.10
Employee + two or more	\$2,167.85	\$1,083.93	\$867.14	\$216.79	\$650.36	\$433.57	\$433.57	\$650.36

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DENTAL INSURANCE - DELTA DENTAL of NEW MEXICO

	Total Premium		Full-Time Employee		3/4-Time Employee		1/2-Time Employee	
			Per Pay Period		Per Pay Period		Per Pay Period	
	Per Month	Per Pay Period	County 80%	Participant 20%	County 60%	Participant 40%	County 40%	Participant 60%
Employee only	\$34.18	\$17.09	\$13.67	\$3.42	\$10.25	\$6.84	\$6.84	\$10.25
Employee + one	\$81.68	\$40.84	\$32.67	\$8.17	\$24.50	\$16.34	\$16.34	\$24.50
Employee + two or more	\$103.38	\$51.69	\$41.35	\$10.34	\$31.01	\$20.68	\$20.68	\$31.01

VISION INSURANCE - VISION SERVICE PLAN

	Total Premium		Full-Time Employee		3/4-Time Employee		1/2-Time Employee	
			Per Pay Period		Per Pay Period		Per Pay Period	
	Per Month	Per Pay Period	County 80%	Participant 20%	County 60%	Participant 40%	County 40%	Participant 60%
Employee only	\$7.39	\$3.70	\$2.96	\$0.74	\$2.22	\$1.48	\$1.48	\$2.22
Employee + one	\$10.74	\$5.37	\$4.30	\$1.07	\$3.22	\$2.15	\$2.15	\$3.22
Employee + two or more	\$19.26	\$9.63	\$7.70	\$1.93	\$5.78	\$3.85	\$3.85	\$5.78