

## Veolia North America – Hawaii

### 2026 Monthly COBRA Premiums

Federal law requires that most group health plans (including our plan) give employees and their families the opportunity to continue their health care coverage when there is a qualifying event that results in a loss of coverage under an employer's plan. The following rates reflect the monthly cost of continuing coverage.

COBRA Months 1 – 18					
Your Monthly COBRA Premium					
		Employee Only	Employee + 1 Dependent	Family	
<b>Medical – HMSA</b> Preferred Provider Plan (PPO)		\$746.23	\$1,492.46	\$2,238.70	

  

COBRA Months 1 – 18					
Your Monthly COBRA Premium					
		Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<b>Dental –</b>					
Delta Dental of Illinois - Gold		\$39.32	\$81.95	\$77.93	\$111.12
Delta Dental of Illinois - Silver		\$32.43	\$67.59	\$64.28	\$91.65
<b>Vision – VSP</b>					
Silver Plan		\$6.71	\$13.41	\$14.37	\$22.81
Gold Plan		\$14.87	\$29.71	\$31.80	\$50.48

Disability COBRA Months 19 – 29					
Your Monthly COBRA Premium					
		Employee Only	Employee + 1 Dependent	Family	
<b>Medical – HMSA</b> Preferred Provider Plan (PPO)		\$1,119.35	\$2,238.70	\$3,358.04	

  

Disability COBRA Months 19 – 29					
Your Monthly COBRA Premium					
		Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<b>Dental –</b>					
Delta Dental of Illinois - Gold		\$58.98	\$122.92	\$116.90	\$166.68
Delta Dental of Illinois - Silver		\$48.65	\$101.39	\$96.42	\$137.48
<b>Vision – VSP</b>					
Silver Plan		\$10.07	\$20.12	\$21.56	\$34.21
Gold Plan		\$22.31	\$44.57	\$47.71	\$75.72

*Benefits are subject to the terms and conditions of the underlying plan documents. Veolia North America reserves the right to modify or discontinue any benefit plan, program, policy, or change the eligibility requirements for participation at any time.*