



Medical/Dental/Vision Plans Premium Rate Schedule - Plan 1

January 1, 2022 through December 31, 2022

All Employees excluding AAUP, GEOC, Stipend & Non-Represented Employees

	12-Month Employees			9-Month Employees		
	Total Biweekly Costs	University Biweekly Subsidy	Employee Biweekly Cost	Total Biweekly Costs	University Biweekly Subsidy	Employee Biweekly Cost
Blue Cross and Blue Shield						
Single	\$711.51	\$302.01	\$409.50	\$948.68	\$402.68	\$546.00
Two Person	\$1,565.32	\$654.86	\$910.46	\$2,087.10	\$873.15	\$1,213.95
Family	\$1,921.08	\$748.27	\$1,172.81	\$2,561.44	\$997.69	\$1,563.74
Community Blue (PPO)						
Single	\$674.10	\$451.70	\$222.40	\$898.80	\$602.27	\$296.53
Two Person	\$1,483.02	\$1,008.36	\$474.66	\$1,977.36	\$1,344.48	\$632.87
Family	\$1,820.07	\$1,246.66	\$573.41	\$2,426.75	\$1,662.21	\$764.54
Health Alliance Plan (HMO)						
Single	\$375.39	\$287.84	\$87.55	\$500.51	\$383.79	\$116.73
Two Person	\$870.14	\$662.51	\$207.64	\$1,160.19	\$883.34	\$276.85
Family	\$889.02	\$672.47	\$216.55	\$1,185.36	\$896.63	\$288.73
Blue Care Network (HMO)						
Single	\$355.61	\$272.98	\$82.63	\$474.15	\$363.97	\$110.18
Two Person	\$817.90	\$623.62	\$194.28	\$1,090.53	\$831.49	\$259.04
Family	\$835.69	\$632.64	\$203.05	\$1,114.25	\$843.52	\$270.73
<i>Sponsored Dependent</i>	\$497.86	\$0.00	\$497.86	\$663.81	\$0.00	\$663.81
Priority Health (HMO)						
Single	\$174.41	\$137.81	\$36.59	\$232.54	\$183.75	\$48.79
Two Person	\$348.81	\$276.75	\$72.06	\$465.08	\$369.00	\$96.08
Family	\$540.66	\$420.94	\$119.71	\$720.87	\$561.26	\$159.62
<i>Sponsored Dependent</i>	\$209.29	\$0.00	\$209.29	\$279.05	\$0.00	\$279.05
Delta Dental						
Single	\$15.26	\$12.20	\$3.05	\$20.34	\$16.27	\$4.07
Two Person	\$30.51	\$24.41	\$6.10	\$40.68	\$32.55	\$8.14
Family	\$55.68	\$44.55	\$11.14	\$74.25	\$59.40	\$14.85
EyeMed Vision - Basic with Medical						
Single	\$2.32	\$1.16	\$1.16	\$3.09	\$1.54	\$1.54
Two Person	\$4.37	\$2.18	\$2.18	\$5.82	\$2.91	\$2.91
Family	\$6.41	\$3.21	\$3.21	\$8.55	\$4.27	\$4.27
EyeMed Vision - Enhanced with Medical						
Single	\$4.31	\$1.16	\$3.15	\$5.74	\$1.54	\$4.20
Two Person	\$8.13	\$2.18	\$5.95	\$10.84	\$2.91	\$7.93
Family	\$11.93	\$3.21	\$8.73	\$15.91	\$4.27	\$11.63



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Delta Dental (Voluntary/Enrolled in Cash in Lieu of Medical)						
Single	\$15.26	\$0.00	\$15.26	\$20.34	\$0.00	\$20.34
Two Person	\$30.51	\$0.00	\$30.51	\$40.68	\$0.00	\$40.68
Family	\$55.68	\$0.00	\$55.68	\$74.25	\$0.00	\$74.25
EyeMed Vision - Basic (Voluntary/Enrolled in Cash in Lieu of Medical)						
Single	\$4.23	\$0.00	\$4.23	\$5.64	\$0.00	\$5.64
Two Person	\$8.01	\$0.00	\$8.01	\$10.68	\$0.00	\$10.68
Family	\$11.79	\$0.00	\$11.79	\$15.72	\$0.00	\$15.72
EyeMed Vision - Enhanced (Voluntary/Enrolled in Cash in Lieu of Medical)						
Single	\$7.46	\$0.00	\$7.46	\$9.95	\$0.00	\$9.95
Two Person	\$14.12	\$0.00	\$14.12	\$18.82	\$0.00	\$18.82
Family	\$20.78	\$0.00	\$20.78	\$27.70	\$0.00	\$27.70