



# WAYNE STATE UNIVERSITY

## Medical/Dental/Vision Plans Monthly Premium Rate Schedule - **COBRA Plan 1** January 1, 2024 through December 31, 2024

	Unpaid Leave of Absence (Non-FMLA)	COBRA Coverage		
	Monthly Premium	Monthly Premium	Administration Fee	Total COBRA Monthly Cost
<b>Blue Cross and Blue Shield Trad Plan</b>				
Single	\$1,376.18	\$1,376.18	\$27.52	\$1,403.71
Two Person	\$3,027.60	\$3,027.60	\$60.55	\$3,088.15
Family	\$3,715.69	\$3,715.69	\$74.31	\$3,790.01
<b>BCBSM PPO (formerly Community Blue)</b>				
Single	\$1,303.82	\$1,303.82	\$26.08	\$1,329.89
Two Person	\$2,868.40	\$2,868.40	\$57.37	\$2,925.77
Family	\$3,520.31	\$3,520.31	\$70.41	\$3,590.71
<b>Health Alliance Plan (HMO)</b>				
Single	\$835.09	\$835.09	\$16.70	\$851.79
Two Person	\$1,937.40	\$1,937.40	\$38.75	\$1,976.15
Family	\$2,058.49	\$2,058.49	\$41.17	\$2,099.66
<b>Blue Care Network (HMO)*</b>				
Single	\$786.74	\$786.74	\$15.73	\$802.47
Two Person	\$1,825.25	\$1,825.25	\$36.51	\$1,861.76
Family	\$1,932.52	\$1,932.52	\$38.65	\$1,971.17
<b>Priority Health Care (HMO)</b>				
Single	\$399.56	\$399.56	\$7.99	\$407.55
Two Person	\$799.12	\$799.12	\$15.98	\$815.10
Family	\$1,238.63	\$1,238.63	\$24.77	\$1,263.40
<b>Delta Dental - Basic with Medical</b>				
Single	\$32.04	\$32.04	\$0.64	\$32.68
Two Person	\$64.08	\$64.08	\$1.28	\$65.36
Family	\$116.94	\$116.94	\$2.34	\$119.28
<b>Delta Dental - Enhanced with Medical</b>				
Single	\$36.02	\$36.02	\$0.72	\$36.74
Two Person	\$72.05	\$72.05	\$1.44	\$73.49
Family	\$131.49	\$131.49	\$2.63	\$134.12
<b>EyeMed Vision - Basic with Medical</b>				
Single	\$4.63	\$4.63	\$0.09	\$4.72
Two Person	\$8.74	\$8.74	\$0.17	\$8.91
Family	\$12.82	\$12.82	\$0.26	\$13.08
<b>EyeMed Vision - Enhanced with Medical</b>				
Single	\$8.62	\$8.62	\$0.17	\$8.79
Two Person	\$16.26	\$16.26	\$0.33	\$16.59
Family	\$23.86	\$23.86	\$0.48	\$24.34

\*Enrolled in medical or waived both medical and Cash-in-Lieu of Medical



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	Monthly Premium	Monthly Premium	Administration Fee	Total COBRA Monthly Cost
<b>Delta Dental - Basic (Voluntary/Enrolled in Cash in Lieu of Medical)</b>				
Single	\$32.04	\$32.04	\$0.64	\$32.68
Two Person	\$64.08	\$64.08	\$1.28	\$65.36
Family	\$116.94	\$116.94	\$2.34	\$119.28
<b>Delta Dental - Enhanced (Voluntary/Enrolled in Cash in Lieu of Medical)</b>				
Single	\$36.02	\$36.02	\$0.72	\$36.74
Two Person	\$72.05	\$72.05	\$1.44	\$73.49
Family	\$131.49	\$131.49	\$2.63	\$134.12
<b>EyeMed Vision - Basic (Voluntary/Enrolled in Cash in Lieu of Medical)</b>				
Single	\$8.46	\$8.46	\$0.17	\$8.63
Two Person	\$16.02	\$16.02	\$0.32	\$16.34
Family	\$23.58	\$23.58	\$0.47	\$24.05
<b>EyeMed Vision - Enhanced (Voluntary/Enrolled in Cash in Lieu of Medical)</b>				
Single	\$14.92	\$14.92	\$0.30	\$15.22
Two Person	\$28.24	\$28.24	\$0.56	\$28.80
Family	\$41.56	\$41.56	\$0.83	\$42.39
<b>*Blue Care Network (HMO)</b>				
<i>COBRA rates for any member currently enrolled in Medicare</i>				
Single with Medicare A&B	\$1,009.34	\$1,009.34	\$20.19	\$1,029.53
2 Person 1 with 1 without Medicare A&B	\$1,838.26	\$1,838.26	\$36.77	\$1,875.03
2 Person both with Medicare A&B	\$2,018.68	\$2,018.68	\$40.37	\$2,059.05
Family (1 with 2 without Medicare A&B)	\$2,915.84	\$2,915.84	\$58.32	\$2,974.16

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