



**Medical/Dental/Vision Plans Premium Rate Schedule - Plan 2**  
**January 1, 2025 through December 31, 2025**  
**AAUP, GEOC & Non-Represented Employees and Stipend Recipients**

	12-Month Employees			9-Month Employees		
	Total Bi-weekly Costs	University Bi-weekly Subsidy	Employee Bi-weekly (per pay) Cost	Total Bi-weekly Costs	University Bi-weekly Subsidy	Employee Bi-weekly (per pay) Cost
<b>Blue Cross Blue Shield Trad Plan</b>						
Single	\$703.96	\$327.26	\$376.70	\$938.61	\$436.34	\$502.27
Two Person	\$1,548.71	\$711.97	\$836.74	\$2,064.95	\$949.30	\$1,115.65
Family	\$1,900.69	\$831.92	\$1,068.77	\$2,534.25	\$1,109.22	\$1,425.03
<b>BCBSM PPO</b>						
Single	\$656.68	\$439.50	\$217.18	\$875.57	\$586.01	\$289.56
Two Person	\$1,444.69	\$981.53	\$463.16	\$1,926.25	\$1,308.71	\$617.54
Family	\$1,773.03	\$1,213.73	\$559.30	\$2,364.04	\$1,618.31	\$745.73
<b>Health Alliance Plan (HMO)</b>						
Single	\$435.74	\$330.09	\$105.65	\$580.99	\$440.12	\$140.87
Two Person	\$1,010.92	\$761.05	\$249.87	\$1,347.89	\$1,014.73	\$333.16
Family	\$1,089.35	\$812.70	\$276.65	\$1,452.46	\$1,083.60	\$368.86
<b>Blue Care Network (HMO)</b>						
Single	\$426.73	\$322.76	\$103.97	\$568.97	\$430.35	\$138.62
Two Person	\$981.48	\$738.13	\$243.35	\$1,308.63	\$984.16	\$324.47
Family	\$1,066.82	\$794.43	\$272.39	\$1,422.42	\$1,059.24	\$363.18
<i>Sponsored Dependent</i>	\$597.42	\$0.00	\$597.42	\$796.56	\$0.00	\$796.56
<b>Priority Health Care (HMO)</b>						
Single	\$204.59	\$158.94	\$45.65	\$272.78	\$211.92	\$60.86
Two Person	\$409.17	\$319.00	\$90.17	\$545.56	\$425.33	\$120.23
Family	\$634.22	\$486.44	\$147.78	\$845.62	\$648.58	\$197.04
<i>Sponsored Dependent</i>	\$245.50	\$0.00	\$245.50	\$327.34	\$0.00	\$327.34
<b>Delta Dental - Basic with Medical*</b>						
Single	\$16.79	\$12.59	\$4.20	\$22.38	\$16.79	\$5.59
Two Person	\$33.58	\$25.19	\$8.39	\$44.77	\$33.58	\$11.19
Family	\$61.28	\$45.96	\$15.32	\$81.70	\$61.28	\$20.42
<b>Delta Dental - Enhanced with Medical*</b>						
Single	\$18.88	\$12.59	\$6.29	\$25.17	\$16.79	\$8.38
Two Person	\$37.75	\$25.18	\$12.57	\$50.34	\$33.58	\$16.76
Family	\$68.90	\$45.96	\$22.94	\$91.86	\$61.28	\$30.58
<b>EyeMed Vision - Basic with Medical*</b>						
Single	\$2.32	\$1.16	\$1.16	\$3.09	\$1.55	\$1.54
Two Person	\$4.38	\$2.19	\$2.19	\$5.83	\$2.92	\$2.91
Family	\$6.42	\$3.21	\$3.21	\$8.55	\$4.28	\$4.27
<b>EyeMed Vision - Enhanced with Medical*</b>						
Single	\$4.31	\$1.16	\$3.15	\$5.74	\$1.54	\$4.20
Two Person	\$8.13	\$2.19	\$5.94	\$10.84	\$2.91	\$7.93
Family	\$11.93	\$3.21	\$8.72	\$15.91	\$4.28	\$11.63

\*University subsidy provided if enrolled in medical or waived both medical and Cash in Lieu of Medical. Stipend recipients are not eligible for Cash in Lieu of Medical.



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<b>Voluntary Plans</b>						
<b>Delta Dental - Basic - Voluntary (Enrolled in Cash in Lieu of Medical)</b>						
Single	\$16.79	\$0.00	<b>\$16.79</b>	\$22.38	\$0.00	<b>\$22.38</b>
Two Person	\$33.58	\$0.00	<b>\$33.58</b>	\$44.77	\$0.00	<b>\$44.77</b>
Family	\$61.28	\$0.00	<b>\$61.28</b>	\$81.70	\$0.00	<b>\$81.70</b>
<b>Delta Dental - Enhanced - Voluntary (Enrolled in Cash in Lieu of Medical)</b>						
Single	\$18.88	\$0.00	<b>\$18.88</b>	\$25.17	\$0.00	<b>\$25.17</b>
Two Person	\$37.75	\$0.00	<b>\$37.75</b>	\$50.34	\$0.00	<b>\$50.34</b>
Family	\$68.90	\$0.00	<b>\$68.90</b>	\$91.86	\$0.00	<b>\$91.86</b>
<b>EyeMed Vision - Basic - Voluntary (Enrolled in Cash in Lieu of Medical)</b>						
Single	\$4.23	\$0.00	<b>\$4.23</b>	\$5.64	\$0.00	<b>\$5.64</b>
Two Person	\$8.01	\$0.00	<b>\$8.01</b>	\$10.68	\$0.00	<b>\$10.68</b>
Family	\$11.79	\$0.00	<b>\$11.79</b>	\$15.72	\$0.00	<b>\$15.72</b>
<b>EyeMed Vision - Enhanced - Voluntary (Enrolled in Cash in Lieu of Medical)</b>						
Single	\$7.46	\$0.00	<b>\$7.46</b>	\$9.95	\$0.00	<b>\$9.95</b>
Two Person	\$14.12	\$0.00	<b>\$14.12</b>	\$18.83	\$0.00	<b>\$18.83</b>
Family	\$20.78	\$0.00	<b>\$20.78</b>	\$27.71	\$0.00	<b>\$27.71</b>

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