Medical/Dental/Vision Plans Premium Rate Schedule - Plan 2

January 1, 2024 through December 31, 2024

AAUP, GEOC & Non-Represented Employees and Stipend Recipients with OEPs

	12-Month Employees with OEPs			9-Month Employees with OEPs		
	Employee Pre-tax Contribution	Employee Post-tax Contribution	Imputed Income Amount	Employee Pre-tax Contribution	Employee Post-tax Contribution	Imputed Income Amount
Blue Cross and Blue Shield Trad Plan						
Single + OEP	$365.04	$445.82	$356.68	$486.72	$594.43	$475.57
Two Person + OEP	$810.86	$230.51	$103.87	$1,081.15	$307.34	$138.49
Family + OEP/OEP's Family	$1,041.37	$0.00	$0.00	$1,388.49	$0.00	$0.00
Single + OEP's Family	$365.04	$676.33	$460.55	$486.72	$901.77	$614.07
BCBSM PPO (formerly Community Blue)						
Single + OEP	$207.32	$234.16	$514.44	$276.43	$312.22	$685.92
Two Person + OEP	$441.48	$91.21	$220.70	$588.64	$121.62	$294.27
Family + OEP/OEP's Family	$532.70	$0.00	$0.00	$710.26	$0.00	$0.00
Single + OEP's Family	$207.32	$325.38	$735.15	$276.43	$433.83	$980.19
Health Alliance Plan (HMO)						
Single + OEP	$95.64	$131.00	$400.12	$127.52	$174.67	$533.49
Two Person + OEP	$226.64	$20.75	$37.59	$302.18	$27.67	$50.12
Family + OEP/OEP's Family	$247.39	$0.00	$0.00	$329.86	$0.00	$0.00
Single + OEP's Family	$95.64	$151.75	$437.71	$127.52	$202.34	$583.62
Blue Care Network (HMO)						
Single + OEP	$88.02	$120.89	$372.22	$117.36	$161.19	$496.29
Two Person + OEP	$208.91	$17.44	$29.26	$278.55	$23.25	$39.01
Family + OEP/OEP's Family	$226.35	$0.00	$0.00	$301.80	$0.00	$0.00
Single + OEP's Family	$88.02	$138.33	$401.47	$117.36	$184.44	$535.29
Priority Health Care (HMO)						
Single + OEP	$41.10	$39.98	$149.46	$54.80	$53.31	$199.27
Two Person + OEP	$81.08	$52.61	$155.77	$108.11	$70.15	$207.69
Family + OEP/OEP's Family	$133.69	$0.00	$0.00	$178.25	$0.00	$0.00
Single + OEP's Family	$41.10	$92.59	$305.22	$54.80	$123.45	$406.96
Delta Dental - Basic with Medical*						
Single + OEP	$4.00	$4.00	$12.01	$5.34	$5.34	$16.02
Two Person + OEP	$8.01	$6.61	$19.82	$10.68	$8.81	$26.43
Family + OEP/OEP's Family	$14.62	$0.00	$0.00	$19.49	$0.00	$0.00
Single + OEP's Family	$4.00	$10.61	$31.84	$5.34	$14.15	$42.45
Delta Dental - Enhanced with Medical*						
Single + OEP	$6.00	$6.00	$12.01	$8.00	$8.00	$16.02
Two Person + OEP	$12.00	$9.90	$19.82	$15.99	$13.19	$26.43
Family + OEP/OEP's Family	$21.89	$0.00	$0.00	$29.19	$0.00	$0.00
Single + OEP's Family	$6.00	$15.89	$31.84	$8.00	$21.19	$42.45
EyeMed Vision - Basic with Medical*						
Single + OEP	$1.16	$1.03	$1.03	$1.54	$1.37	$1.37
Two Person + OEP	$2.19	$1.02	$1.02	$2.91	$1.36	$1.36
Family + OEP/OEP's Family	$3.21	$0.00	$0.00	$4.27	$0.00	$0.00
Single + OEP's Family	$1.16	$2.05	$2.05	$1.54	$2.73	$2.73

*University subsidy provided if enrolled in medical or waived both medical and Cash-in-Lieu of Medical

11/13/2023

WAYNE STATE UNIVERSITY

Medical/Dental/Vision Plans Premium Rate Schedule - Plan 2

January 1, 2024 through December 31, 2024

AAUP, GEOC & Non-Represented Employees and Stipend Recipients with OEPs

	12-Month Employees with OEPs			9-Month Employees with OEPs		
	Employee Pre-tax Contribution	Employee Post-tax Contribution	Imputed Income Amount	Employee Pre-tax Contribution	Employee Post-tax Contribution	Imputed Income Amount
EyeMed Vision - Enhanced with Medical*						
Single + OEP	$3.15	$2.79	$1.03	$4.20	$3.73	$1.37
Two Person + OEP	$5.95	$2.78	$1.02	$7.93	$3.71	$1.36
Family + OEP/OEP's Family	$8.73	$0.00	$0.00	$11.63	$0.00	$0.00
Single + OEP's Family	$3.15	$5.57	$2.05	$4.20	$7.43	$2.73
Voluntary Plans						
Delta Dental - Basic - Voluntary (Enrolled in Cash-in-Lieu of Medical)						
Single + OEP	$16.02	$16.02	$0.00	$21.36	$21.36	$0.00
Two Person + OEP	$32.04	$26.43	$0.00	$42.72	$35.24	$0.00
Family + OEP/OEP's Family	$58.47	$0.00	$0.00	$77.96	$0.00	$0.00
Single + OEP's Family	$16.02	$42.45	$0.00	$21.36	$56.60	$0.00
Delta Dental - Enhanced - Voluntary (Enrolled in Cash-in-Lieu of Medical)						
Single + OEP	$18.01	$18.01	$0.00	$24.02	$24.02	$0.00
Two Person + OEP	$36.02	$29.72	$0.00	$48.03	$39.63	$0.00
Family + OEP/OEP's Family	$65.74	$0.00	$0.00	$87.66	$0.00	$0.00
Single + OEP's Family	$18.01	$47.73	$0.00	$24.02	$63.64	$0.00
EyeMed Vision - Basic - Voluntary (Enrolled in Cash-in-Lieu of Medical)						
Single + OEP	$4.23	$3.78	$0.00	$5.64	$5.04	$0.00
Two Person + OEP	$8.01	$3.78	$0.00	$10.68	$5.04	$0.00
Family + OEP/OEP's Family	$11.79	$0.00	$0.00	$15.72	$0.00	$0.00
Single + OEP's Family	$4.23	$7.56	$0.00	$5.64	$10.08	$0.00
EyeMed Vision - Enhanced - Voluntary (Enrolled in Cash in Lieu of Medical)						
Single + OEP	$7.46	$6.66	$0.00	$9.95	$8.88	$0.00
Two Person + OEP	$14.12	$6.66	$0.00	$18.83	$8.88	$0.00
Family + OEP/OEP's Family	$20.78	$0.00	$0.00	$27.71	$0.00	$0.00
Single + OEP's Family	$7.46	$13.32	$0.00	$9.95	$17.76	$0.00

*University subsidy provided if enrolled in medical or waived both medical and Cash-in-Lieu of Medical

11/13/2023