



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

January 1, 2025 through December 31, 2025

All Non-Academic Represented Union Employees **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	\$390.27	\$475.72	\$408.94	\$520.36	\$634.29	\$545.25
Two Person + OEP	\$865.99	\$240.35	\$128.26	\$1,154.65	\$320.47	\$171.01
Family + OEP/OEP's Family	\$1,106.34	\$0.00	\$0.00	\$1,475.12	\$0.00	\$0.00
Single + OEP's Family	\$390.27	\$716.07	\$537.20	\$520.36	\$954.76	\$716.26
BCBSM PPO						
Single + OEP	\$229.71	\$261.02	\$577.13	\$306.27	\$348.04	\$769.48
Two Person + OEP	\$490.73	\$102.41	\$246.81	\$654.31	\$136.54	\$329.10
Family + OEP/OEP's Family	\$593.14	\$0.00	\$0.00	\$790.85	\$0.00	\$0.00
Single + OEP's Family	\$229.71	\$363.43	\$823.94	\$306.27	\$484.58	\$1,098.58
Health Alliance Plan (HMO)						
Single + OEP	\$113.16	\$154.13	\$454.08	\$150.88	\$205.50	\$605.46
Two Person + OEP	\$267.29	\$28.13	\$54.81	\$356.38	\$37.51	\$73.07
Family + OEP/OEP's Family	\$295.42	\$0.00	\$0.00	\$393.89	\$0.00	\$0.00
Single + OEP's Family	\$113.16	\$182.26	\$508.89	\$150.88	\$243.01	\$678.53
Blue Care Network (HMO)						
Single + OEP	\$113.36	\$151.60	\$443.86	\$151.15	\$202.13	\$591.81
Two Person + OEP	\$264.96	\$30.91	\$60.69	\$353.28	\$41.21	\$80.93
Family + OEP/OEP's Family	\$295.87	\$0.00	\$0.00	\$394.49	\$0.00	\$0.00
Single + OEP's Family	\$113.36	\$182.51	\$504.55	\$151.15	\$243.34	\$672.74
Priority Health Care (HMO)						
Single + OEP	\$49.98	\$48.86	\$170.17	\$66.64	\$65.15	\$226.89
Two Person + OEP	\$98.84	\$62.38	\$178.56	\$131.79	\$83.17	\$238.09
Family + OEP/OEP's Family	\$161.22	\$0.00	\$0.00	\$214.96	\$0.00	\$0.00
Single + OEP's Family	\$49.98	\$111.24	\$348.73	\$66.64	\$148.32	\$464.98
Delta Dental - Basic with Medical*						
Single + OEP	\$3.36	\$3.36	\$13.43	\$4.48	\$4.47	\$17.92
Two Person + OEP	\$6.72	\$5.54	\$22.16	\$8.95	\$7.39	\$29.54
Family + OEP/OEP's Family	\$12.26	\$0.00	\$0.00	\$16.34	\$0.00	\$0.00
Single + OEP's Family	\$3.36	\$8.90	\$35.59	\$4.48	\$11.86	\$47.46
Delta Dental - Enhanced with Medical*						
Single + OEP	\$5.45	\$5.44	\$13.43	\$7.26	\$7.26	\$17.91
Two Person + OEP	\$10.89	\$8.99	\$22.16	\$14.52	\$11.98	\$29.54
Family + OEP/OEP's Family	\$19.88	\$0.00	\$0.00	\$26.50	\$0.00	\$0.00
Single + OEP's Family	\$5.45	\$14.43	\$35.59	\$7.26	\$19.24	\$47.45
EyeMed Vision - Basic with Medical*						
Single + OEP	\$1.16	\$1.03	\$1.02	\$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	\$2.04	\$1.54	\$2.73	\$2.73

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



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EyeMed Vision - Enhanced with Medical*						
Single + OEP	\$3.15	\$2.80	\$1.02	\$4.20	\$3.73	\$1.37
Two Person + OEP	\$5.95	\$2.78	\$1.02	\$7.93	\$3.70	\$1.37
Family + OEP/OEP's Family	\$8.73	\$0.00	\$0.00	\$11.63	\$0.00	\$0.00
Single + OEP's Family	\$3.15	\$5.58	\$2.04	\$4.20	\$7.43	\$2.74
Voluntary Plans						
Delta Dental - Basic - Voluntary (Enrolled in Cash in Lieu of Medical)						
Single + OEP	\$16.79	\$16.79	\$0.00	\$22.38	\$22.39	\$0.00
Two Person + OEP	\$33.58	\$27.70	\$0.00	\$44.77	\$36.93	\$0.00
Family + OEP/OEP's Family	\$61.28	\$0.00	\$0.00	\$81.70	\$0.00	\$0.00
Single + OEP's Family	\$16.79	\$44.49	\$0.00	\$22.38	\$59.32	\$0.00
Delta Dental - Enhanced - Voluntary (Enrolled in Cash in Lieu of Medical)						
Single + OEP	\$18.88	\$18.87	\$0.00	\$25.17	\$25.17	\$0.00
Two Person + OEP	\$37.75	\$31.15	\$0.00	\$50.34	\$41.52	\$0.00
Family + OEP/OEP's Family	\$68.90	\$0.00	\$0.00	\$91.86	\$0.00	\$0.00
Single + OEP's Family	\$18.88	\$50.02	\$0.00	\$25.17	\$66.69	\$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

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