Fermilab
COBRA Monthly Premiums
Rates Effective 01/01/2024 - 12/31/2024

Note: Medical costs are not applicable if electing Retiree medical coverage.

Coverage Tier	Blue Advantage HMO	BCBSIL PPO	BCBSIL PPO HDHP (no banking)	DELTA Dental High	DELTA Dental Low	EyeMed
Single	$799.50	$1,033.05	$891.24	$43.38	$35.32	$9.39
Employee & Spouse	$1,538.38	$2,087.83	$1,800.07	$86.77	$70.65	$17.83
Employee & Child(ren)	$1,474.62	$1,887.02	$1,628.24	$100.45	$75.82	$18.77
Family	$2,287.66	$2,981.13	$2,571.23	$153.44	$116.64	$27.59

Note: Overage dependent child coverage: Single rate

Coverage Tier	Blue Advantage HMO	BCBSIL PPO	BCBSIL PPO HDHP (no banking)	DELTA Dental High	DELTA Dental Low	EyeMed
Single	$799.50	$1,033.05	$891.24	$43.38	$35.32	$9.39