

## 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 &	<i><i>ϕ</i>, , , ,</i>	φ1,000.00	<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>	φ 10.00		φ <i>γ</i> .ο <i>γ</i>
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

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AE Cost Sheet COBRA	BEN-AE-COB-002	10/01/2009	006	10/08/2023