

**Fermilab  
COBRA Monthly Premiums  
Rates Effective 01/01/2025 - 12/31/2025**

**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	\$832.28	\$1,106.46	\$954.58	\$44.59	\$36.30	\$9.39
Employee & Spouse	\$1,601.46	\$2,236.20	\$1,927.98	\$89.19	\$72.62	\$17.83
Employee & Child(ren)	\$1,535.08	\$2,021.11	\$1,743.95	\$103.26	\$77.93	\$18.77
Family	\$2,381.45	\$3,192.99	\$2,753.96	\$157.73	\$119.90	\$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	\$832.28	\$1,106.46	\$954.58	\$44.59	\$36.30	\$9.39

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