State of Delaware
Group Health Insurance Plan
Rates Effective July 1, 2024

Please note: The specific premiums (rates) referenced in this document apply to State of Delaware employees. Flex credits offered to school district or charter school employees to reduce their employee premiums for health care are not reflected in this information. Please see your organization's HR/Benefits Office for information about your flex credits. Employees who are eligible for and receiving reduced premiums due to double state share eligibility are not reflected in this information. Non-State Participating Group Employees should contact their HR/Benefits Office within their organization for premium information.

	Total Monthly Premium (Rate)	Monthly Premium (Rate) Paid By the State	Monthly Premium (Rate) Paid By State of DE Employee	*Monthly Dollar Amount Change for Employee Contribution**
Highmark Delaware First State Basic Plan				
Employee	$1,049.58	$1,007.60	$41.98	*+ $8.92*
Employee & Spouse	$2,171.54	$2,084.66	$86.88	*+ $18.46*
Employee & Child(ren)	$1,595.46	$1,531.64	$63.82	*+ $13.56*
Family	$2,714.52	$2,605.92	$108.60	*+ $23.06*
Aetna CDH Gold Plan				
Employee	$1,086.30	$1,031.98	$54.32	*+ $11.54*
Employee & Spouse	$2,252.36	$2,139.74	$112.62	*+ $23.92*
Employee & Child(ren)	$1,659.68	$1,576.70	$82.98	*+ $17.62*
Family	$2,861.42	$2,718.36	$143.06	*+ $30.38*
Aetna HMO Plan				
Employee	$1,095.74	$1,024.50	$71.24	*+ $15.14*
Employee & Spouse	$2,310.26	$2,160.08	$150.18	*+ $31.90*
Employee & Child(ren)	$1,676.20	$1,567.24	$108.96	*+ $23.14*
Family	$2,882.68	$2,695.30	$187.38	*+ $39.80*
Highmark Delaware Comprehensive PPO Plan				
Employee	$1,198.24	$1,039.48	$158.76	*+ $33.72*
Employee & Spouse	$2,486.48	$2,157.00	$329.48	*+ $69.98*
Employee & Child(ren)	$1,846.70	$1,602.02	$244.68	*+ $51.96*
Family	$3,108.44	$2,696.58	$411.86	*+ $87.46*
Dominion National HMO Select Dental Plan				
Employee	$27.94	$0.00	$27.94	*No Change*
Employee & Spouse	$51.96	$0.00	$51.96	*No Change*
Employee & Child(ren)	$56.00	$0.00	$56.00	*No Change*
Family	$76.08	$0.00	$76.08	*No Change*
Delta Dental PPO Plus Premier Plan				
Employee	$37.44	$0.00	$37.44	*No Change*
Employee & Spouse	$76.42	$0.00	$76.42	*No Change*
Employee & Child(ren)	$75.02	$0.00	$75.02	*No Change*
Family	$125.20	$0.00	$125.20	*No Change*
EyeMed Low Vision Plan				
Employee	$6.48	$0.00	$6.48	*No Change*
Employee & Spouse	$10.24	$0.00	$10.24	*No Change*
Employee & Child(ren)	$10.42	$0.00	$10.42	*No Change*
Family	$16.84	$0.00	$16.84	*No Change*
EyeMed High Vision Plan				
Employee	$13.06	$0.00	$13.06	*No Change*
Employee & Spouse	$20.64	$0.00	$20.64	*No Change*
Employee & Child(ren)	$21.04	$0.00	$21.04	*No Change*
Family	$33.94	$0.00	$33.94	*No Change*

**Shows the change in dollar amount of the new rates effective July 1, 2024 compared against the current rates that are in effect (as of July 1, 2023).*