

## 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. State share and pensioner contributions depend on years of service and the date of hire/retirement. Non-State Participating Group Employees should contact their HR/Benefits Office within their organization for premium information.

	Total Monthly Premium (Rate)	State Pays	Monthly Premium (Rate) Paid By State of DE Employee
<b>Highmark Delaware First State Basic Plan</b>			
Employee	\$1,049.58	\$1,007.60	\$41.98
Employee & Spouse	\$2,171.54	\$2,084.66	\$86.88
Employee & Child(ren)	\$1,595.46	\$1,531.64	\$63.82
Family	\$2,714.52	\$2,605.92	\$108.60

<b>Aetna CDH Gold Plan</b>			
Employee	\$1,086.30	\$1,031.98	\$54.32
Employee & Spouse	\$2,252.36	\$2,139.74	\$112.62
Employee & Child(ren)	\$1,659.68	\$1,576.70	\$82.98
Family	\$2,861.42	\$2,718.36	\$143.06

<b>Aetna HMO Plan</b>			
Employee	\$1,095.74	\$1,024.50	\$71.24
Employee & Spouse	\$2,310.26	\$2,160.08	\$150.18
Employee & Child(ren)	\$1,676.20	\$1,567.24	\$108.96
Family	\$2,882.68	\$2,695.30	\$187.38

<b>Highmark Delaware Comprehensive PPO Plan</b>			
Employee	\$1,198.24	\$1,039.48	\$158.76
Employee & Spouse	\$2,486.48	\$2,157.00	\$329.48
Employee & Child(ren)	\$1,846.70	\$1,602.02	\$244.68
Family	\$3,108.44	\$2,696.58	\$411.86

<b>Dominion National HMO Select Dental Plan</b>			
Employee	\$27.94	\$0.00	\$27.94
Employee & Spouse	\$51.96	\$0.00	\$51.96
Employee & Child(ren)	\$56.00	\$0.00	\$56.00
Family	\$76.08	\$0.00	\$76.08

<b>Delta Dental PPO Plus Premier Plan</b>			
Employee	\$37.44	\$0.00	\$37.44
Employee & Spouse	\$76.42	\$0.00	\$76.42
Employee & Child(ren)	\$75.02	\$0.00	\$75.02
Family	\$125.20	\$0.00	\$125.20

<b>EyeMed Low Vision Plan</b>			
Employee	\$6.48	\$0.00	\$6.48
Employee & Spouse	\$10.24	\$0.00	\$10.24
Employee & Child(ren)	\$10.42	\$0.00	\$10.42
Family	\$16.84	\$0.00	\$16.84

<b>EyeMed High Vision Plan</b>			
Employee	\$13.06	\$0.00	\$13.06
Employee & Spouse	\$20.64	\$0.00	\$20.64
Employee & Child(ren)	\$21.04	\$0.00	\$21.04
Family	\$33.94	\$0.00	\$33.94