2024 HEALTH PLAN OPTIONS 3 Tier Prescriptions

	ADMIN, EIEA, ESPA, & NONA							
	OPTION 1		OPTION 2		OPTION 3		OPTION 4	
Group Name	WMHIP		WMHIP		WMHIP		WMHIP	
Network	BCBS		BCBS		BCBS		BCBS	
Plan Year	1/1/24 - 12/31/24		1/1/24 - 12/31/24		1/1/24 - 12/31/24		1/1/24 - 12/31/24	
Plan Name	VERSATILE		SELECT		H.S.A. FLEXIBLE BLUE 2		Simply Blue	
Type of Plan	PPO		PPO		PPO-HDHP		PPO	
PLAN BASICS	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**
Individual Deductible	$250	$500	$250	$500	$1,600	$3,200	$500	$1,000
Family Deductible	$500	$1,000	$500	$1,000	$3,200	$6,400	$1,000	$2,000
Coinsurance Level	90%	70%	100%	80%	100%	80%	80%	60%
Coinsurance MAX Individual	$1,000	$2,000	NA	NA	NA	NA	$2,500	N/A
Coinsurance MAX Family	$2,000	$4,000	NA	NA	NA	NA	$5,000	N/A
Out of Pocket MAX Individual	$2,500	$2,500	$2,500	$2,500	$2,600	$5,100	$4,500	$4,500
Out of Pocket MAX Family	$5,000	$5,000	$5,000	$5,000	$5,200	$10,200	$9,000	$9,000
	In-Network OOP incl. Deductibles, Coinsurance & Copays. Out-Network includes Coinsurance							
OTHER PLAN DETAILS								
Preventative Care	100%		100%		100%		100%	Not Covered
Hospital Services	90% after Ded	70% after Ded	100% after Ded	80% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Inpatient Care	90% after Ded	70% after Ded	100% after Ded	80% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Emergency Care (waived if admitted)	90% after Ded		100%		100% after Ded		$150	
Office/Specialist Visits	$20	70% after Ded	$20	80% after Ded	100% after Ded	80% after Ded	$30/$50	60% after Ded
Urgent Care Visit	$20	70% after Ded	$20	80% after Ded	100% after Ded	80% after Ded	$60	60% after Ded
Chiropractic (24 Visits, See Note Below)	90% after Ded	70% after Ded	100%	80% after Ded	100% after Ded (24 visits per member per calendar year)	80% after Ded	$30 Copay (12 visits per member per calendar year)	80% after Ded
Therapeutic Massage (24 Visits, See Note Below)	90% after Ded	70% after Ded	100%	80% after Ded	Not Covered		Not Covered	
Acupuncture	Covered		Covered		Not Covered		Not Covered	
Adult Hearing Aids	Covered		Covered		Covered		Covered	
Bariatric Surgery	90% after Ded		Covered		Covered		50% after Ded	
Physical, Occupational & Speech Therapy (60 Visits)	90% after Ded		Covered		Covered		80% after Ded up to 30 combined visits per calendar year	60% after Ded
Prescription Drugs	Rx1		Rx1		Rx 6			
Generic	10		10		$10 after Ded		20	
Formulary Brand	40		40		$40 after Ded		40	
Non-Formulary Brand	40		40		$40 after Ded		80	
Mail Order Prescriptions (90 Days)	2x		2x		2x after Ded		2x Copay	
MONTHLY COST (PREMIUM + TAXES)								
Subscriber	Jan - Dec 2024		Jan - Dec 2024		Jan - Dec 2024		Jan - Dec 2024	
Single	$792.29		$879.84		$729.44		$624.53	
2 Person	$1,782.65		$1,979.64		$1,641.25		$1,405.19	
Family	$2,218.43		$2,463.56		$2,042.45		$1,748.69	
MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) - MONTHLY CAP AMOUNT PAID BY EMPLOYER								
Subscriber	***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***	
Single	**$150.39**		**$237.94**		**$87.54**		**$0.00**	
2 Person	**$440.23**		**$637.22**		**$298.83**		**$62.77**	
Family	**$467.78**		**$712.91**		**$291.80**		**$0.00**	
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2								
Subscriber	***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***	
Single	**$75.19**		**$118.97**		**$43.77**		**$0.00**	
2 Person	**$220.11**		**$318.61**		**$149.41**		**$31.38**	
Family	**$233.89**		**$356.45**		**$145.90**		**$0.00**	

2024 HEALTH PLAN OPTIONS 3 Tier Prescriptions

	ESPA - Single Subscriber Only							
	OPTION 1		**OPTION 2**		**OPTION 3**		**OPTION 4**	
Group Name	**WMHIP**		**WMHIP**		**WMHIP**		**WMHIP**	
Network	**BCBS**		**BCBS**		**BCBS**		**BCBS**	
Plan Year	1/1/24 - 12/31/24		1/1/24 - 12/31/24		1/1/24 - 12/31/24		1/1/24 - 12/31/24	
Plan Name	**VERSATILE**		**SELECT**		**H.S.A. FLEXIBLE BLUE 2**		**Simply Blue**	
Type of Plan	PPO		PPO		PPO-HDHP		PPO	
PLAN BASICS	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**	**IN-Net**	**Out-Net**
Individual Deductible	$250	$500	$250	$500	$1,600	$3,200	$500	$1,000
Family Deductible	$500	$1,000	$500	$1,000	$3,200	$6,400	$1,000	$2,000
Coinsurance Level	90%	70%	100%	80%	100%	80%	80%	60%
Coinsurance MAX Individual	$1,000	$2,000	NA	NA	NA	NA	$2,500	N/A
Coinsurance MAX Family	$2,000	$4,000	NA	NA	NA	NA	$5,000	N/A
Out of Pocket MAX Individual	$2,500	$2,500	$2,500	$2,500	$2,600	$5,100	$4,500	$4,500
Out of Pocket MAX Family	$5,000	$5,000	$5,000	$5,000	$5,200	$10,200	$9,000	$9,000
	In-Network OOP incl. Deductibles, Coinsurance & Copays. Out-Network includes Coinsurance							
OTHER PLAN DETAILS								
Preventative Care	100%		100%		100%		100%	Not Covered
Hospital Services	90% after Ded	70% after Ded	100% after Ded	80% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Inpatient Care	90% after Ded	70% after Ded	100% after Ded	80% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Emergency Care (waived if admitted)	90% after Ded		100%		100% after Ded		$150	
Office/Specialist Visits	$20	70% after Ded	$20	80% after Ded	100% after Ded	80% after Ded	$30/$50	60% after Ded
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Therapeutic Massage (24 Visits, See Note Below)	90% after Ded	70% after Ded	100%	80% after Ded	Not Covered		Not Covered	
Acupuncture	Covered		Covered		Not Covered		Not Covered	
Adult Hearing Aids	Covered		Covered		Covered		Covered	
Bariatric Surgery	90% after Ded		Covered		Covered		50% after Ded	
Physical, Occupational & Speech Therapy (60 Visits)	90% after Ded		Covered		Covered		80% after Ded up to 30 combined visits per calendar year	60% after Ded
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Formulary Brand	40		40		$40 after Ded		40	
Non-Formulary Brand	40		40		$40 after Ded		80	
Mail Order Prescriptions (90 Days)	2x		2x		2x after Ded		2x Copay	
MONTHLY COST (PREMIUM + TAXES)								
Subscriber	Jan - Dec 2024		Jan - Dec 2024		Jan - Dec 2024		Jan - Dec 2024	
Single	$792.29		$879.84		$729.44		$624.53	
2 Person	$1,782.65		$1,979.64		$1,641.25		$1,405.19	
Family	$2,218.43		$2,463.56		$2,042.45		$1,748.69	
MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) - MONTHLY CAP AMOUNT PAID BY EMPLOYER								
Subscriber	***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***	
Single	**$150.39**		**$237.94**		**$87.54**		**$0.00**	
2 Person	**$1,140.75**		**$1,337.74**		**$999.35**		**$763.29**	
Family	**$1,576.53**		**$1,821.66**		**$1,400.55**		**$1,106.79**	
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2								
Subscriber	***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***		***Jan - Dec 2024***	
Single	**$75.19**		**$118.97**		**$43.77**		**$0.00**	
2 Person	**$570.38**		**$668.87**		**$499.68**		**$381.65**	
Family	**$788.27**		**$910.83**		**$700.28**		**$553.40**	