2023 HEALTH PLAN OPTIONS 3 Tier Prescriptions

OPTION 1		ADMIN NOMA LEIEA								
WMHIP BCBS 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23 1/1/23 - 1/23/1/23				ADMIN, NONA, and EIEA						
Network Pala Year		OPTION 1		OPTION 2		OPTION 3		OPTION 4		
Plan Name Plan Name Processor Proc	Group Name	WMHIP		WMHIP		WMHIP		WMHIP		
Plan Name	Network									
PPO	Plan Year									
N-Net Out-Net N-Net N-	Plan Name	VERS	ATILE	SEL	ECT	H.S.A. FLEXI	BLE BLUE 2			
Individual Deductible	Type of Plan	PF	90			PPO-I	HDHP	PI	20	
Family Deductible	PLAN BASICS	IN-Net	Out-Net	IN-Net Out-Net						
Coinsurance Level	Individual Deductible	\$250	\$500	\$250	\$500	\$1,500	\$3,000	\$500	\$1,000	
Scientified	Family Deductible	\$500	\$1,000	\$500	\$1,000	\$3,000	\$6,000	\$1,000	\$2,000	
School S	Coinsurance Level	90%	70%	100%	80%	100%	80%	80%	60%	
Subscriber Sub	Coinsurance MAX Individual	\$1,000	\$2,000	NA	NA	NA	NA	\$2,500	N/A	
Dut of Pocket MAX Family	Coinsurance MAX Family	\$2,000	\$4,000	NA	NA	NA	NA	\$5,000	N/A	
Dut of Pocket MAX Family	Out of Pocket MAX Individual	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500	\$5,000	\$4,500	\$4,500	
DTHER PLAN DETAILS	Out of Pocket MAX Family	\$5,000		\$5,000	\$5,000	\$5,000	\$10,000		\$9,000	
Preventative Care 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 1	,							1 ' '	. ,	
Hospital Services 190% after Ded 70% after Ded 100% after Ded 80% after Ded 60% after Ded 100% aft	OTHER PLAN DETAILS									
Solution	Preventative Care	100%		100%		100%		100%	Not Covered	
Subscriber Sub	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	
S20	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	
Second Care Visit Second Covered Second	Emergency Care (waived if admitted)	90% after Ded				•		\$150		
Chiropractic (24 Visits, See Note Below)	Office/Specialist Visits	\$20	70% after Ded	\$20	80% after Ded	100% after Ded	80% after Ded	\$30/\$50	60% after Ded	
Chiropractic (24 Visits, See Note Below) 90% after Ded 70% after Ded 100% 80% after Ded 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%	Urgent Care Visit	\$20	70% after Ded	\$20	80% after Ded	100% after Ded	80% after Ded	\$60	60% after Ded	
Therapeutic Massage (24 Visits, See Note Below) 90% after Ded 100% 80% after Ded Not Covered Not Covered Not Covered Cov										
Acupuncture Covered	Chiropractic (24 Visits, See Note Below)	90% after Ded			80% after Ded			per calendar year)	80% after Ded	
Adult Hearing Aids Covered Cove	Therapeutic Massage (24 Visits, See Note Below)									
Covered Cove	·									
Physical, Occupational & Speech Therapy (60 Visits) Covered Covered Covered Covered per calendar year 60% after	Adult Hearing Aids									
Physical, Occupational & Speech Therapy (60 Visits) Covered Covered Covered per calendar year per ca	Bariatric Surgery	Covered		Covered		Covered		Covered		
Rx1		Coursed		Covered		Coursed		30 combined visits	500/ - 6 5 - 1	
10								per calendar year	60% after Ded	
Formulary Brand 40 40 \$40 after Ded 40 80								20		
Non-Formulary Brand 40 40 \$40 after Ded 80						,				
Mail Order Prescriptions (90 Days) 2x 2x 2x 2x after Ded 2x Copay MONTHLY COST (PREMIUM + TAXES) Subscriber Jan - Dec 2023 Jan - Dec 202	•	· ·		· ·		·				
MONTHLY COST (PREMIUM + TAXES) Subscriber Jan - Dec 2023 Jan - Dec 2023 Jan - Dec 2023 Single \$754.57 \$837.94 \$694.71 \$594.79 2 Person \$1,697.76 \$1,885.37 \$1,563.09 \$1,338.27 Family \$2,112.79 \$2,346.25 \$1,945.19 \$1,665.41 MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12)-MONTHLY CAP AMOUNT PAID BY EMPLOYER Jan - Dec 2023 South of the control	•					,		+		
Subscriber Jan - Dec 2023 Jan - Dec 2023 Jan - Dec 2023 Jan - Dec 2023 Single \$754.57 \$837.94 \$694.71 \$594.79 2 Person \$1,697.76 \$1,885.37 \$1,563.09 \$1,338.27 Family \$2,112.79 \$2,346.25 \$1,945.19 \$1,665.41 MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12)-MONTHLY CAP AMOUNT PAID BY EMPLOYER Jan - Dec 2023 South of the company	, , , , , ,	2x				ZA GILEI DEU		Zx COpay		
Single \$754.57 \$837.94 \$694.71 \$594.79 2 Person \$1,697.76 \$1,885.37 \$1,563.09 \$1,338.27 Family \$2,112.79 \$2,346.25 \$1,945.19 \$1,665.41 MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12)-MONTHLY CAP AMOUNT PAID BY EMPLOYER Subscriber Jan - Dec 2023 Solution of the color of the colo		Jan - Dec 2023		lan - Dec 2023		Jan - Dec 2023		lan - Dec 2023		
2 Person \$1,697.76 \$1,885.37 \$1,563.09 \$1,338.27 Family \$2,112.79 \$2,346.25 \$1,945.19 \$1,665.41 MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12)-MONTHLY CAP AMOUNT PAID BY EMPLOYER Subscriber Jan - Dec 2023 Jan - Dec 2023 Jan - Dec 2023 Jan - Dec 2023 Single \$137.95 \$221.32 \$78.09 \$0.00										
Family \$2,112.79 \$2,346.25 \$1,945.19 \$1,665.41 MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST / 12)- MONTHLY CAP AMOUNT PAID BY EMPLOYER Subscriber	-	· ·		· ·		'		· '		
MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) - MONTHLY CAP AMOUNT PAID BY EMPLOYER Subscriber Jan - Dec 2023 Jan		' '								
Single \$137.95 \$221.32 \$78.09 \$0.00	MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) -			¥2,540.25		⊋1, 545.15		Ş1,005.41		
	Subscriber							Jan - Dec 2023		
2 Percen \$4.09.21 \$606.92 \$272.64 \$40.72	Single	•		-				\$0.00		
2 FC13011 3400.21 323.02 348.72	2 Person	\$408.21		\$595.82		\$273.54		\$48.72		
Family \$431.09 \$664.55 \$263.49 \$0.00		\$431.09		\$664.55		\$263.49		\$0.00		
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2	EMPLOYEE PREMIUM SHARE/2									
		Jan - Dec 2023		Jan - Dec 2023		Jan - Dec 2023		Jan - Dec 2023		
	· ·	\$68.97		\$110.66		\$39.04		\$0.00		
				\$297.91		\$136.77		\$24.36		
Family \$215.54 \$332.27 \$131.74 \$0.00	Family	\$21	5.54	\$332.27		\$131.74		\$0.00		

2023 HEALTH PLAN OPTIONS 3 Tier Prescriptions

			ESPA					
	OPTION 1		OPTION 2		OPTION 3		OPTION 4	
Group Name	WM	1HIP	WM	HIP	WM	HIP	WM	1HIP
Network	BCBS		BCBS		BCBS		BCBS	
Plan Year	1/1/23 - 12/31/23		1/1/23 - 12/31/23		1/1/23 - 12/31/23		1/1/23 - 12/31/23	
Plan Name	VERSATILE		SELECT		H.S.A. FLEXIBLE BLUE 2		Simply Blue	
Type of Plan		90	PPO		PPO-H			20
PLAN BASICS	IN-Net	Out-Net	IN-Net	Out-Net	IN-Net	Out-Net	IN-Net	Out-Net
Individual Deductible	\$250	\$500	\$250	\$500	\$1,500	\$3,000	\$500	\$1,000
Family Deductible	\$500	\$1,000	\$500	\$1,000	\$3,000	\$6,000	\$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 ¢2.500	NA ¢2.500	NA ¢2.200	NA 64.500	\$5,000	N/A
Out of Pocket MAX Individual	\$2,500	\$2,500	\$2,500	\$2,500	\$2,300	\$4,500	\$4,500	\$4,500
Out of Pocket MAX Family	\$5,000	\$5,000	\$5,000	\$5,000	\$4,600 & Copays. Out-Network	\$9,000	\$9,000	\$9,000
OTHER PLAN DETAILS					. a copays. Out-NetWOII	ciuucs comsuralite		
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		\$1	
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
							\$30 Copay	
							(12 visits per	
Chinamantia (24 Visita Can Nata Balann)	000/ -ft D	700/ -ft Dl	1000/	000/ -ft DI	1000/ -ft D	000/ -ft DI	member per	000/ -ft D
Chiropractic (24 Visits, See Note Below)	90% after Ded	70% after Ded	100% 100%	80% after Ded 80% after Ded	100% after Ded		calendar year)	80% after Ded
Therapeutic Massage (24 Visits, See Note Below) Acupuncture	90% after Ded 70% after Ded		Covered		Not Covered Not Covered		Not Covered Not Covered	
Adult Hearing Aids	Covered Covered		Covered		Covered		Covered	
Bariatric Surgery		ered	Covered		Covered		Covered	
Surfactive Surfactive							551	
							80% after Ded up	
							to 30 combined visits per calendar	
Physical, Occupational & Speech Therapy (60 Visits)	Cov	ered	Cove	red	Cove	ered	year	60% after Ded
Prescription Drugs	R	x1	Rx	1	Rx	6		
Generic	1	.0	10)	\$10 after Ded		2	0
Formulary Brand		10	40)	\$40 aft	er Ded		.0
Non-Formulary Brand	4	0	40)	\$40 after Ded		80	
Mail Order Prescriptions (90 Days)	2	2x	25	K	2x after Ded		2x Copay	
MONTHLY COST (PREMIUM + TAXES)								
<u>Subscriber</u>		ec 2023	Jan - De		Jan - De		Jan - Dec 2023	
Single		4.58	\$837		\$694		\$594.79 \$1.338.27	
2 Person	\$1,697.77 \$2,112.79		\$1,885.37		\$1,563.09		\$1,338.27	
Family MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) -	\$2,112./9		\$2,346.24		\$1,945.19		\$1,665.41	
MONTHLY CAP AMOUNT PAID BY EMPLOYER								
<u>Subscriber</u>	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023
Single	\$145.87	\$137.95	\$229.23	\$221.32	\$86.00	\$78.09	\$0.00	\$0.00
2 Person	\$424.77	\$408.21	\$612.37	\$595.82	\$290.09	\$273.54	\$65.27	\$48.72
Family	\$452.67	\$431.09	\$686.12	\$664.55	\$285.07	\$263.49	\$5.29	\$0.00
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2								
Subscriber	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023
Single	\$72.94	\$68.97	\$114.62	\$110.66	\$43.00	\$39.04	\$0.00	\$0.00
2 Person	\$212.38	\$204.11	\$306.18	\$297.91	\$145.04	\$136.77	\$32.63	\$24.36
Family	\$226.33	\$215.54	\$343.06	\$332.27	\$142.53	\$130.77	\$2.64	\$0.00
·	Ÿ==0.55	Ÿ==3.5·	75.5.00	7002127	Ψ 2.33	7-0-117-7	7-10-1	75.00

2023 HEALTH PLAN OPTIONS 3 Tier Prescriptions

	ESPA - Single Subscriber Only							
	OPTION 1		OPTION 2		OPTIO		OPTION 4	
Group Name		THIP	WM		WM			IHIP
Network		BS	BCI		BCI			
Plan Year	1/1/23 - 12/31/23		1/1/23 - 12/31/23		1/1/23 - 12/31/23		BCBS 1/1/23 - 12/31/23	
Plan Name	VERSATILE		1/1/23 - 12/31/23 SELECT		H.S.A. FLEXIBLE BLUE 2		Simply Blue	
Type of Plan		20	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	\$1,500	\$3,000	\$500	\$1,000
Family Deductible	\$500	\$1,000	\$500	\$1,000	\$3,000	\$6,000	\$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	\$2,300	\$4,500	\$4,500	\$4,500
Out of Pocket MAX Family	\$5,000	\$5,000	\$5,000	\$5,000	\$4,600	\$9,000	\$9,000	\$9,000
			In-Network OOP incl. De	eductibles, Coinsurance	& Copays. Out-Network	includes Coinsurance	•	
OTHER PLAN DETAILS								
Preventative Care	100%	•	100%	T	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%	ı	100% after Ded		\$1	
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
							\$30 Copay	
							(12 visits per member per	
Chiropractic (24 Visits, See Note Below)	90% after Ded	70% after Ded	100%	80% after Ded	100% after Ded	80% after Ded	calendar year)	80% after Ded
Therapeutic Massage (24 Visits, See Note Below)	90% after Ded		100%	80% after Ded	Not Co		Not Co	overed
Acupuncture	Covered		Covered		Not Covered		Not Covered	
Adult Hearing Aids	Covered		Covered		Covered		Covered	
Bariatric Surgery	Cov	ered	Cove	red	Covered		Covered	
							000/ 6: 0. 1	
							80% after Ded up to 30 combined	
							visits per calendar	
Physical, Occupational & Speech Therapy (60 Visits)	Cov	ered	Cove	ered	Cove	red	year	60% after Ded
Prescription Drugs		x1	Rx		Rx	6		
Generic		0	10		\$10 afte			0
Formulary Brand		.0	40		\$40 afte	er Ded		.0
Non-Formulary Brand		.0	40		\$40 afte		80	
Mail Order Prescriptions (90 Days)	2	X	2)	K	2x afte	r Ded	2x Copay	
MONTHLY COST (PREMIUM + TAXES)							lan - Doc 2022	
Subscriber		ec 2023	Jan - De		Jan - De		Jan - Dec 2023 \$594.79	
Single		4.58	\$837		\$694			
2 Person	\$1,697.77 \$2,112.79		\$1,885.37 \$2,346.24		\$1,563.09 \$1,945.19		\$1,338.27 \$1,665.41	
Family MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) -	\$2,1.	12.79	\$2,34	6.24	\$1,94	5.19	\$1,6	55.41
MONTHLY CAP AMOUNT PAID BY EMPLOYER								
<u>Subscriber</u>	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023
Single	\$145.87	\$137.95	\$229.23	\$221.32	\$86.00	\$78.09	\$0.00	\$0.00
2 Person	\$1,089.06	\$1,081.14	\$1,276.66	\$1,268.75	\$954.38	\$946.47	\$729.56	\$721.65
Family	\$1,504.08	\$1,496.17	\$1,737.53	\$1,729.63	\$1,336.48	\$1,328.57	\$1,056.70	\$1,048.79
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2								
Subscriber	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023	Jan - Jun 2023	July - Dec 2023
Single	\$72.94	\$68.97	\$114.62	\$110.66	\$43.00	\$39.04	\$0.00	\$0.00
2 Person	\$544.53	\$540.57	\$638.33	\$634.37	\$477.19	\$473.23	\$364.78	\$360.82
Family	\$752.04	\$748.08	\$868.77	\$864.81	\$668.24	\$664.28	\$528.35	\$524.39

IMPORTANT NOTES:

- 1) 90% Coinsurance for WMHIP Versatile plan means you pay 10% of medical care (Up to \$1000 indiv/\$2000 fam maximum) except you don't pay the 10% for Office Visits, Rx or Preventive Care
- 2) Emergency Care "Waived if admitted" Refers to co-pays NOT co-insurance
- 3) All plans provide for the required ACA free medications/supplies.
- 4) ESPA moves to 2023 CAP effective 7/1/23 per Contract Language.
- 5) The per pay period premium share is only paid by the employee on the 1st and 2nd pays of each month; months with a 3rd pay do NOT include a deduction for health insurance.