2023 HEALTH PLAN OPTIONS 3 Tier Prescriptions

	ADMIN, NONA, and EIEA							
	OPTION 1		OPTION 2		OPTION 3		OPTION 4	
Group Name	WMHIP		WMHIP		WMHIP		WMHIP	
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	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	$1,500	$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	$2,500	$5,000	$4,500	$4,500
Out of Pocket MAX Family	$5,000	$5,000	$5,000	$5,000	$5,000	$10,000	$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	Covered		Covered		Covered		Covered	
Physical, Occupational & Speech Therapy (60 Visits)	Covered		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 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								
Subscriber	***Jan - Dec 2023***		***Jan - Dec 2023***		***Jan - Dec 2023***		***Jan - Dec 2023***	
Single	**$137.95**		**$221.32**		**$78.09**		**$0.00**	
2 Person	**$408.21**		**$595.82**		**$273.54**		**$48.72**	
Family	**$431.09**		**$664.55**		**$263.49**		**$0.00**	
PER PAY PERIOD EMPLOYEE PREMIUM SHARE = MONTHLY EMPLOYEE PREMIUM SHARE/2								
Subscriber	***Jan - Dec 2023***		***Jan - Dec 2023***		***Jan - Dec 2023***		***Jan - Dec 2023***	
Single	**$68.97**		**$110.66**		**$39.04**		**$0.00**	
2 Person	**$204.11**		**$297.91**		**$136.77**		**$24.36**	
Family	**$215.54**		**$332.27**		**$131.74**		**$0.00**	

2023 HEALTH PLAN OPTIONS 3 Tier Prescriptions

	ESPA							
	OPTION 1		OPTION 2		OPTION 3		OPTION 4	
Group Name	WMHIP		WMHIP		WMHIP		WMHIP	
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	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	$1,500	$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. 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	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	Covered		Covered		Covered		Covered	
Physical, Occupational & Speech Therapy (60 Visits)	Covered		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 2023		Jan - Dec 2023		Jan - Dec 2023		Jan - Dec 2023	
Single	$754.58		$837.94		$694.71		$594.79	
2 Person	$1,697.77		$1,885.37		$1,563.09		$1,338.27	
Family	$2,112.79		$2,346.24		$1,945.19		$1,665.41	
MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) - MONTHLY CAP AMOUNT PAID BY EMPLOYER								
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	**$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**	**$131.74**	**$2.64**	**$0.00**

2023 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	1/1/23 - 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	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	$1,500	$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. 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	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	Covered		Covered		Covered		Covered	
Physical, Occupational & Speech Therapy (60 Visits)	Covered		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 2023		Jan - Dec 2023		Jan - Dec 2023		Jan - Dec 2023	
Single	$754.58		$837.94		$694.71		$594.79	
2 Person	$1,697.77		$1,885.37		$1,563.09		$1,338.27	
Family	$2,112.79		$2,346.24		$1,945.19		$1,665.41	
MONTHLY EMPLOYEE PREMIUM SHARE = (TOTAL COST /12) - MONTHLY CAP AMOUNT PAID BY EMPLOYER								
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	**$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.