Highmark Basic Option 2024

	Deductible	Employee Only	Employee + One	Family
Preventive Care 100%	HRA Funded by Laitram	$800	$1,200	$1,600
	Employee Responsibility	$1,000	$1,400	$1,800
	Co-Insurance	80% In-Network Providers 60 % of Allowable Charges for Out-of-Network Providers		
	Out of Pocket Maximum	$1,700 In-Network $3,200 Out-of-Network	$2,300 In-Network $4,175 Out-of-Network	$2,900 In-Network $5,150 Out-of-Network
	Annual Maximum Responsibility	$2,700 In-Network $4,200 Out-of-Network	$3,700 In-Network $5,575 Out-of-Network	$4,700 In-Network $6,950 Out-of-Network

Highmark Enhanced Option 2024

	Deductible	Employee Only	Employee + One	Family
Preventive Care 100%	HRA Funded by Laitram	$800	$1,200	$1,600
	Employee Responsibility	$800	$1,100	$1,400
	Co-Insurance	90% In-Network Providers 70 % of Allowable Charges for Out-of-Network Providers		
	Out of Pocket Maximum	$900 In-Network $1,900 Out-of-Network	$1,100 In-Network $2,350 Out-of-Network	$1,300 In-Network $2,800 Out-of-Network
	Annual Maximum Responsibility	$1,700 In-Network $2,700 Out-of-Network	$2,200 In-Network $3,450 Out-of-Network	$2,700 In-Network $4,200 Out-of-Network

Prescription Drug Co-Pays*

**Co-pays go toward satisfying the Out of Pocket Maximum*

Category	Co-Pay	Co-Pay for 90 Day Supply	Discounts @ Laitram Pharmacy
Preventive Medications	$10	$20	$0
Generic	$10	$20	$8
Preferred Brand	$30	$60	$20
Non-Prefered Brand	$50	$100	$40
Specialty	$50	N/A - 30 Day Supply Only	N/A

Laitram®

Health Plan Premiums for 2024

Health Plan Premiums 2024			
BASIC OPTION	Per Pay Period Cost (26 pay periods)		
Coverage Level	Preferred Rate	Non-Preferred Rate	Non-Preferred 2 Rate
Single	$10.33	$33.41	N/A
Employee + 1	$111.60	$134.68	$157.75
Family	$153.27	$176.35	$199.42
Employee Married to Employee	$82.04	$105.12	$128.19
ENHANCED OPTION			
Single	$40.10	$63.18	N/A
Employee + 1	$173.40	$196.48	$219.55
Family	$250.95	$274.03	$297.10
Employee Married to Employee	$94.07	$117.15	$140.22

Preferred Rate: Employee & Spouse (if applicable) have completed all incentive requirements

Non-Preferred Rate: Employee OR Spouse (if applicable) have not completed all incentive requirements

Non-Preferred Rate 2: Employee & Spouse have not completed all incentive requirements

2024 DENTAL RATES		
Coverage Tier	Dental Only Cost Per Pay Period	Dental Plus Orthodontia Cost Per Pay Period
Employee Only	$5.19	$7.03
Family	$15.75	$20.69