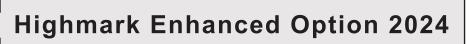




Highmark Basic Option 2024

	Deductible	Employee Only	Employee + One	Family
re	HRA Funded by Laitram	\$800	\$1,200	\$1,600
Cal	Employee Responsibility	\$1,000	\$1,400	\$1,800
tive		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 \$2,700 In-Network		\$2,300 In-Network \$4,175 Out-of-Network	\$2,900 In-Network \$5,150 Out-of-Network	
Pre	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





	Deductible	Employee Only	Employee + One	Family
re	HRA Funded by Laitram	\$800	\$1,200	\$1,600
Ca	Employee Responsibility	\$800	\$1,100	\$1,400
tive 00%	Co-insurance	90 70 % of Allowable		
reventive	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
Pre	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	Discounts @ Laitram	
		90 Day Supply	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	



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	