

WSBAIT Benefit Options-2024/2025



Medical		HDHP		HDHP		HDHP		
	PLAN - C		PLAN - D		PLAN - E		PLAN - G	
Deductible Amount	Single	Family	Single	Family	Single	Family	Single	Family
In-Network	\$2,500	\$5,000	\$3,200	\$6,400	\$5,000	\$10,000	\$6,500	\$13,000
Out-of-Network **	\$5,000	\$10,000	\$5,600	\$11,200	\$10,000	\$20,000	\$13,000	\$26,000
Dr. Office Co-Pay	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist
In-Network	\$40	\$75	Deductible & Co-Insurance		Deductible & Co-Insurance		Deductible & Co-Insurance	
Out-of-Network **	Non-Network Ded & Coins							
Rx Card	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
Generic	\$15	\$15	Deductible & Co-Insurance		Deductible & Co-Insurance		Deductible & Co-Insurance	
Brand Name	\$45	\$85						
Specialty Rx	\$250							
Mail Order & Retail Pharmacy	3 x Monthly co-pay - 3 Month Supply							
Hospital Co-Pay (per facility visit)	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient
In-Network	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Out-of-Network **	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500
Emergency Room Co-pay *	\$250							
Urgent Care Co-pay *	\$75							
*True emergency apply to deductible/coinsurance. Non true emergency \$250 co-pay applied followed by deductible/coinsurance. \$250 applies to max out of pocket.								
Co-Insurance (what happens after the Deductible Amount)								
In-Network Plan Pays	80%		80%		80%		100%	
Out-of-Network ** Plan Pays	50%		50%		50%		50%	
TOTAL Out-of-Pocket (including Deductible, Co-insurance, Office Visit and RX Co-Pays)								
In-Network (Single / Family)	\$6,500	\$13,000	\$3,900	\$7,800	\$5,500	\$11,000	\$6,500	\$13,000
Out-of-Network ** (Single / Family)	\$13,000	\$26,000	\$7,900	\$15,800	\$12,000	\$24,000	\$14,300	\$28,600

**** Non-Network Out-of-Pocket Amount does NOT include amounts in excess of the "Allowable Medicare Reimbursement" PLUS 40%**

2024-2025 Non Wellness Premiums		Plan	Employee	Plan	Employee	Plan	Employee	Plan	Employee
Single		\$1,028.32	\$ 275.00	\$1,001.89	\$ 175.00	\$ 740.88	\$ 75.00	\$ 674.19	\$ 50.00
Family		\$2,448.20	\$ 425.00	\$2,385.25	\$ 225.00	\$1,763.86	\$ 125.00	\$1,605.11	\$ 100.00

This summary is not intended as a complete description of benefits and limitations of each of the Plans offered. Please refer to the Plan Document(s) for a complete list.

This is a Non-Grandfathered Plan, one that complies with the requirements of the Affordable Care Act as well as fully compliant plan with all State of Wyoming insurance mandates.

2024-2025 Wellness Premiums		Plan	Employee	Plan	Employee	Plan	Employee	Plan	Employee
Single		\$ 987.19	\$ 150.00	\$ 961.81	\$ 50.00	\$ 711.24	\$ -	\$ 647.22	\$ -
Family		\$2,350.27	\$ 300.00	\$2,289.84	\$ 100.00	\$1,693.31	\$ -	\$1,540.91	\$ -

Employer Yearly HSA Contribu

Single	\$1,200.00
Family	\$2,400.00