Highmark Basic Option 2025

	Deductible	Employee Only	EE+Sp & EE +Child(ren)	Family
Preventive Care 100%	HRA Funded by Laitram	$500	$1,000	$1,000
	Employee Responsibility	$2,000	$4,000	$4,000
	Co-Insurance	80% In-Network Providers 60 % of Allowable Charges for Out-of-Network Providers		
	Out of Pocket Maximum	$1,500 In-Network $3,000 Out-of-Network	$3,000 In-Network $6,000 Out-of-Network	$3,000 In-Network $6,000 Out-of-Network
	Annual Maximum Responsibility	$3,500 In-Network $7,500 Out-of-Network	$7,000 In-Network $15,000 Out-of-Network	$7,000 In-Network $15,000 Out-of-Network

Highmark Enhanced Option 2025

	Deductible	Employee Only	EE+SP & EE +Child(ren)	Family
Preventive Care 100%	HRA Funded by Laitram	$500	$1,000	$1,000
	Employee Responsibility	$1,000	$2,000	$2,000
	Co-Insurance	90% In-Network Providers 70 % of Allowable Charges for Out-of-Network Providers		
	Out of Pocket Maximum	$500 In-Network $1,000 Out-of-Network	$1,000 In-Network $2,000 Out-of-Network	$1,000 In-Network $2,000 Out-of-Network
	Annual Maximum Responsibility	$1,500 In-Network $3,500 Out-of-Network	$3,000 In-Network $7,000 Out-of-Network	$3,000 In-Network $7,000 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®

2025 Health Plan Premiums			
YOUR PAY PERIOD COST FOR THE BASIC OPTION			
Coverage Level	**Preferred Rate**	**Non-Preferred Rate**	**Non-Preferred 2 Rate**
Employee Only	$18.46	$41.54	N/A
Employee + Spouse	$120.00	$143.08	$166.16
Employee + Child(ren)	$92.31	$115.39	N/A
Family	$161.54	$184.62	$207.70
Employee Married to Employee	$92.31	$115.39	$138.47
YOUR PAY PERIOD COST FOR THE ENHANCED OPTION			
Coverage Level	**Preferred Rate**	**Non-Preferred Rate**	**Non-Preferred 2 Rate**
Employee Only	$46.15	$69.23	N/A
Employee + Spouse	$200.77	$223.85	$246.93
Employee + Child(ren)	$154.62	$177.70	N/A
Family	$270.00	$293.08	$316.16
Employee Married to Employee	$115.38	$138.46	$161.54

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

Non-Preferred Rate: Employee OR Spouse (if applicable) have completed all incentive requirements

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

2025 Dental Rates		
YOUR PAY PERIOD COST		
Coverage Level	**Dental Only Cost**	**Dental + Orthodontia Cost**
Employee Only	$5.19	$7.03
Family	$15.75	$20.69