2015 Medical Marketing Report

MESSA Plan Designs

		MESSA Choices		MESSA Choices		MESSA Choices		MESSA ABC	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$100	$250	$200	$400	$500	$1,000	$1,300	$2,600
	Deductible - Family	$200	$500	$400	$800	$1,000	$2,000	$2,600	$5,200
	Out of Pocket Max - Individual ***(includes deductible)***	$1,100	$2,250	$1,200	$2,400	$1,500	$3,000	$2,300	$4,500
	Out of Pocket Max - Family ***(includes deductible)***	$2,200	$4,500	$2,400	$4,800	$3,000	$6,000	$4,600	$9,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	100%	80%	100%	80%	100%	80%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	80% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Specialist Office Visits	$20	80% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Urgent Care	$25	80% after deductible	$25	80% after deductible	$25	80% after deductible	100% after deductible	80% after deductible
	Diagnostic Lab and X-Ray	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office**	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Substance Abuse*	90% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Chiropractic Services-limited to 38 visits except where noted	$20	80% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Physical, Occupational and Speech Therapy- Limited to 60 combined visits per year	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Ambulance	100% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible	
	Emergency Room	$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		100% after deductible	
	Generic	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay after deductible	Copay plus 25%
	Brand Formulary	$40 Copay		$40 Copay		$40 Copay		$40 Copay after deductible	
	Brand Non-Formulary								
	Mail Order (plus Retail 90-Days)	2 x Copay	Not Covered	2 x Copay	Not Covered	2 x Copay	Not Covered	2 x Copay	Not Covered
Financials		Current	Renewal	Current	Renewal	Current	Renewal	Current	Renewal
	Single	$609.61	$614.11	$591.25	$595.60	$544.37	$548.38	$492.53	$496.16
	2 Person	$1,369.77	$1,379.87	$1,328.44	$1,338.23	$1,222.95	$1,231.97	$1,106.33	$1,114.48
	Family	$1,704.23	$1,716.80	$1,652.80	$1,664.98	$1,521.53	$1,532.75	$1,376.39	$1,386.54

This is intended to be an easy to read summary. Where differences between this and the contract occur, the contract will prevail.

The renewal rates do not include taxes and fees.

Non-Pak rates used for comparison.

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WMHIP Plan Designs

		BCBSM Parapro Option		BCBSM Parapro Option		BCBSM Parapro Option		BCBSM Security Option		BCBSM Security Option		BCBSM Flex Blue	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$250	$500	$250	$500	$500	$1,000	$250	$500	$250	$500	$1,300	$2,600
	Deductible - Family	$500	$1,000	$500	$1,000	$1,000	$2,000	$500	$1,000	$500	$1,000	$2,500	$5,200
	Out of Pocket Max - Individual ***(includes deductible)***	$750	$2,250	$2,250	$4,500	$2,500	$5,000	$1,250	$2,500	$1,250	$2,500	$2,300	$4,500
	Out of Pocket Max - Family ***(includes deductible)***	$1,500	$5,000	$4,500	$5,000	$5,000	$10,000	$2,500	$5,000	$2,500	$5,000	$4,600	$9,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	90%	80%	90%	70%	90%	70%	90%	70%	90%	70%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible
	Specialist Office Visits	$20	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible
	Urgent Care	$20	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible
	Diagnostic Lab and X-Ray	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office**	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Outpatient Substance Abuse*	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Chiropractic Services-limited to 24 visits except where noted	$20	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible
	Physical, Occupational and Speech Therapy- Limited to 60 combined visits per year	90% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Ambulance	90% after in-network deductible		90% after in-network deductible		90% after in-network deductible		90% after in-network deductible		90% after in-network deductible		100% after deductible	
	Emergency Room	$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		100% after deductible	
	Generic	$7 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$7 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$15 Copay	Copay plus 25%	$10 Copay after deductible	Copay plus 25%
	Brand Formulary	$35 Copay		$40 Copay		$35 Copay		$20 Copay		$30 Copay		$20 Copay after deductible	
	Brand Non-Formulary	$70 Copay		$80 Copay		$70 Copay		$40 Copay		$30 Copay		$20 Copay after deductible	
	Mail Order (plus Retail 90-Days)	2 x copay	Not Covered	2 x copay	Not Covered	2 x copay	Not Covered	2 x copay	Not Covered	2 x copay	Not Covered	2 x copay	Not Covered
Financials		**Current**	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**	**Current**	**Renewal**
	Single	$499.63	$529.61	$480.39	$509.21	$471.94	$500.26	$496.74	$526.54	$492.74	$522.30	$424.76	$450.25
	2 Person	$1,199.07	$1,271.01	$1,152.90	$1,222.07	$1,132.62	$1,200.58	$1,192.19	$1,263.72	$1,182.59	$1,253.55	$1,019.40	$1,080.56
	Family	$1,498.87	$1,588.80	$1,441.16	$1,527.63	$1,415.81	$1,500.76	$1,490.24	$1,579.65	$1,478.24	$1,566.93	$1,274.27	$1,350.73

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Aetna Plan Designs

		Aetna PPO		Aetna PPO		Aetna PPO		Aetna PPO		Aetna PPO	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$100	$250	$200	$400	$250	$500	$500	$1,000	$1,300	$2,600
	Deductible - Family	$200	$500	$400	$800	$500	$1,000	$1,000	$2,000	$2,600	$5,200
	Out of Pocket Max - Individual ***(includes deductible)***	$1,100	$2,250	$1,200	$2,400	$1,250	$2,500	$1,500	$3,000	$2,300	$4,500
	Out of Pocket Max - Family ***(includes deductible)***	$2,200	$4,500	$2,400	$4,800	$2,500	$5,000	$3,000	$6,000	$4,600	$9,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	100%	80%	100%	80%	100%	80%	100%	80%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Specialist Office Visits	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Urgent Care	$25	80% after deductible	$25	80% after deductible	100% after deductible	80% after deductible	$25	80% after deductible	100% after deductible	80% after deductible
	Diagnostic Lab and X-Ray	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office**	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$30	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Substance Abuse*	90% after deductible	80% after deductible	100% after deductible	80% after deductible	$30	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Chiropractic Services-limited to 38 visits except where noted	$20	80% after deductible	$20	80% after deductible	$20	80% after deductible	$30 [1]	80% after deductible	$20	80% after deductible
	Physical, Occupational and Speech Therapy- Limited to 60 combined visits per year	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Ambulance	100% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible	
	Emergency Room	$50 copay; waived if admitted		$50 copay; waived if admitted		$50 copay; waived if admitted		$50 copay; waived if admitted		100% after deductible	
	Generic[2]	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay after deductible	Copay plus 25%
	Brand Formulary	$40 Copay		$40 Copay		$40 Copay		$40 Copay		$40 Copay after deductible	
	Brand Non-Formulary										
	Mail Order (plus Retail 90-Days)	2 x Copay	Not Covered	2 x Copay	Not Covered	2 x Copay	Not Covered	2 x Copay	Not Covered	2 x Copay	Not Covered
Financials	*Illustrative Rates*	**Proposed**		**Proposed**		**Proposed**		**Proposed**		**Proposed**	
	Single	$650.03		$630.44		$549.91		$580.46		$525.19	
	2 Person	$1,460.53		$1,416.47		$1,319.77		$1,303.99		$1,179.64	
	Family	$1,817.15		$1,762.31		$1,649.72		$1,622.35		$1,467.59	

[1)] Chiropractic Visits limited to 24 annually

[2)] Rx plan is a two or three tier plan and not a match to the Rx Saver.

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BCBSM Plan Designs

		BCBSM PPO		BCBSM PPO		BCBSM PPO		BCBSM PPO		BCBSM HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$100	$250	$250	$500	$250	$500	$500	$1,000	$1,300	$2,600
	Deductible - Family	$200	$500	$500	$1,000	$500	$1,000	$1,000	$2,000	$2,600	$5,200
	Out of Pocket Max - Individual ***(includes deductible)***	$1,250	$2,250	$1,250	$2,250	$1,250	$2,250	$2,000	$3,500	$2,250	$4,500
	Out of Pocket Max - Family ***(includes deductible)***	$2,500	$4,500	$2,500	$4,500	$2,500	$4,500	$4,000	$7,000	$4,500	$9,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	100%	80%	100%	80%	100%	80%	100%	80%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Specialist Office Visits	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Urgent Care	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Diagnostic Lab and X-Ray	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office*	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Chiropractic Services-limited to 24 visits except where noted	$20	80% after deductible	$20	80% after deductible	$30	80% after deductible	$20	80% after deductible	100% after deductible(1)	80% after deductible(2)
	Physical, Occupational and Speech Therapy- Limited to 60 combined visits per year	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible(1)	80% after deductible(2)
	Ambulance	100% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible	
	Emergency Room	$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury		$50 copay; waived if admitted or for accidental injury	
	Generic	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$7 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay after deductible	Copay plus 20% after deductible
	Brand Formulary	$40 Copay		$40 Copay		$35 Copay		$40 Copay		$60 Copay after deductible	
	Brand Non-Formulary					$70 Copay					
	Mail Order (plus Retail 90-Days)	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered
Financials		**Proposed**		**Proposed**		**Proposed**		**Proposed**		**Proposed**	
	Single	$818.94		$795.32		$758.04		$760.46		$527.53	
	2 Person	$1,963.92		$1,907.23		$1,817.76		$1,823.58		$1,264.55	
	Family	$2,460.65		$2,389.79		$2,277.96		$2,285.23		$1,586.43	

This is intended to be an easy to read summary. Where differences between this and the contract occur, the contract will prevail.

Plan design subject to change due to Health Care Reform requirements. The illustrative rates include taxes and fees.

(1) Limited to 12 visits.

(2) Limited to 30 visits.

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Priority Health Plan Designs

		Priority Health PPO 1		Priority Health PPO 2		Priority Health PPO 3		Priority Health PPO 4		Priority Health PPO 5	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$250	$500	$250	$500	$250	$500	$250	$500	$500	$1,000
	Deductible - Family	$500	$1,000	$500	$1,000	$500	$1,000	$500	$1,000	$1,000	$2,000
	Out of Pocket Max - Individual ***(includes deductible)***	$6,350	$12,700	$6,350	$12,700	$6,350	$12,700	$6,350	$12,700	$6,350	$12,700
	Out of Pocket Max - Family ***(includes deductible)***	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	100%	80%	100%	80%	90%	70%	90%	70%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	80% after deductible	$30	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	80% after deductible
	Specialist Office Visits	$20	80% after deductible	$30	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	80% after deductible
	Urgent Care	$40	80% after deductible	$50	80% after deductible	$40	70% after deductible	$40	70% after deductible	$40	80% after deductible
	Diagnostic Lab and X-Ray	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office*	$20	80% after deductible	$30	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	80% after deductible
	Outpatient Substance Abuse	$20	80% after deductible	$30	80% after deductible	$20	70% after deductible	$20	70% after deductible	$20	80% after deductible
	Chiropractic Services-Visit limits apply	$20	50% after deductible	$30	50% after deductible	$20	50% after deductible	$20	50% after deductible	$20	50% after deductible
	Physical, Occupational and Speech Therapy- Visit limits apply	$20	50% after deductible	$30	50% after deductible	$20	50% after deductible	$20	50% after deductible	$20	50% after deductible
	Ambulance	$50 copay		$50 copay		$100 copay		$100 copay		$50 copay	
	Emergency Room	$50 copay; waived if admitted		$50 copay; waived if admitted		$100 copay; waived if admitted		$100 copay; waived if admitted		$50 copay; waived if admitted	
	Generic	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$15 Copay	Not Covered	$10 Copay	Not Covered
	Brand Formulary	$40 Copay		$40 Copay		$40 Copay		$30 Copay		$40 Copay	
	Brand Non-Formulary			$80 Copay		$80 Copay					
	Mail Order (plus Retail 90-Days)	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered
Financials		Proposed		Proposed		Proposed		Proposed		Proposed	
	Single	$654.79		$608.18		$575.36		$578.06		$630.87	
	2 Person	$1,471.18		$1,459.63		$1,380.86		$1,387.34		$1,417.25	
	Family	$1,830.40		$1,824.54		$1,726.08		$1,734.18		$1,763.28	

This is intended to be an easy to read summary. Where differences between this and the contract occur, the contract will prevail.

Plan design subject to change due to Health Care Reform requirements. The illustrative rates do not include taxes and fees.

(1) Limited to 12 visits.

(2) Limited to 30 visits.

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Priority Health Plan Designs

		Priority Health PPO6		Priority Health PPO 7		Priority Health PPO HSA8		Priority Health POS HSA9		Priority Health POS 10		Priority Health POS 11		Priority Health PPO 12	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$500	$1,000	$250	$500	$1,300	$3,000	$1,300	$3,000	$250	$500	$500	$1,000	$500	$1,000
	Deductible - Family	$1,000	$2,000	$500	$1,000	$2,600	$6,000	$2,600	$6,000	$500	$1,000	$1,000	$2,000	$1,000	$2,000
	Out of Pocket Max - Individual *(inclu*	$6,350	$12,700	$6,350	$12,700	$2,000	$4,000	$2,000	$4,000	$6,350	$12,700	$6,350	$12,700	$6,350	$12,700
	Out of Pocket Max - Family *(includes*	$12,700	$25,400	$12,700	$25,400	$4,000	$8,000	$4,000	$8,000	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	90%	70%	90%	70%	100%	80%	100%	80%	100%	80%	100%	80%	90%	70%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	80% after deductible	$20	80% after deductible	$20	70% after deductible
	Specialist Office Visits	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	80% after deductible	$20	80% after deductible	$20	70% after deductible
	Urgent Care	$40	70% after deductible	$40	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$30	80% after deductible	$30	80% after deductible	$30	70% after deductible
	Diagnostic Lab and X-Ray	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible
	Inpatient Mental Heath & Substance Abuse	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible
	Outpatient Mental Heath - *Physician's*	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	80% after deductible	$20	80% after deductible	$20	70% after deductible
	Outpatient Substance Abuse	$20	70% after deductible	$20	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	80% after deductible	$20	80% after deductible	$20	70% after deductible
	Chiropractic Services-Visit limits app	$20	50% after deductible	$20	50% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	50% after deductible	$20	50% after deductible	$20	50% after deductible
	Physical, Occupational and Speech limits apply	$20	50% after deductible	$20	50% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	$20	50% after deductible	$20	50% after deductible	$20	50% after deductible
	Ambulance	$100 copay		$50 copay		100% after in-network deductible		100% after in-network deductible		$50 copay		$50 copay		$50 copay	
	Emergency Room	$100 copay; waived if admitted		$50 copay; waived if admitted		100% after in-network deductible		100% after in-network deductible		$50 copay; waived if admitted		$50 copay; waived if admitted		$50 copay; waived if admitted	
	Generic	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay after deductible	Not Covered	$10 Copay after deductible	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
	Brand Formulary	$40 Copay		$40 Copay		$40 Copay after deductible		$40 Copay after deductible		$40 Copay		$40 Copay		$40 Copay	
	Brand Non-Formulary	$80 Copay		$80 Copay											
	Mail Order (plus Retail 90-Days)	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered
Financials		Proposed		Proposed		Proposed		Proposed		Proposed		Proposed		Proposed	
	Single	$557.43		$580.35		$539.16		$479.76		$585.31		$555.25		$522.32	
	2 Person	$1,337.83		$1,392.78		$1,211.01		$1,077.64		$1,314.72		$1,247.20		$1,173.24	
	Family	$1,672.29		$1,741.05		$1,506.63		$1,340.69		$1,635.65		$1,551.65		$1,459.62	

This is intended to be an easy to read summary. Where differences be

Plan design subject to change due to Health Care Reform requirements

(1) Limited to 12 visits.

(2) Limited to 30 visits.

2015 Medical Marketing Report

UHC Plan Designs

		UHC		UHC		UHC		UHC	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$0	$1,500	$250	$500	$500	$1,000	$1,500	$5,000
	Deductible - Family	$0	$3,000	$500	$1,000	$1,000	$2,000	$3,000	$15,000
	Out of Pocket Max - Individual ***(includes deductible)***	$2,500	$5,000	$4,000	$8,000	$4,000	$8,000	$2,500	$10,000
	Out of Pocket Max - Family ***(includes deductible)***	$5,000	$10,000	$8,000	$16,000	$8,000	$16,000	$5,000	$30,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	100%	80%	100%	80%	100%	80%	100%	70%
	Preventive Care	100%	80% after deductible	100%	80% after deductible	100%	80% after deductible	100%	70% after deductible
	PCP Office Visits	$20	80% after deductible	$25	80% after deductible	$20	80% after deductible	100% after deductible	70% after deductible
	Specialist Office Visits	$40	80% after deductible	$25	80% after deductible	$40	80% after deductible	100% after deductible	70% after deductible
	Urgent Care	$75	80% after deductible	$75	80% after deductible	$75	80% after deductible	100% after deductible	70% after deductible
	Diagnostic Lab and X-Ray	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	70% after deductible
	Inpatient Mental Heath & Substance Abuse	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	70% after deductible
	Outpatient Mental Heath - *Physician's Office*	100% after $40 Copay	80% after deductible	100% after $25 Copay	80% after deductible	100% after $40 Copay	80% after deductible	100% after deductible	70% after deductible
	Outpatient Substance Abuse	100% after $40 Copay	80% after deductible	100% after $25 Copay	80% after deductible	100% after $40 Copay	80% after deductible	100% after deductible	70% after deductible
	Chiropractic Services-limited to 20 visits except where noted	$20	80% after deductible	$25	80% after deductible	$20	80% after deductible	100% after deductible	70% after deductible
	Physical, Occupational and Speech Therapy- Visit Limits apply.	$20	80% after deductible	$25	80% after deductible	$20	80% after deductible	100% after deductible	70% after deductible
	Ambulance	$100		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible	
	Emergency Room	$150 copay		$100 copay		$100 copay		100% after in-network deductible	
	Generic	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay after deductible	$10 Copay after deductible
	Brand Formulary	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay after deductible	$35 Copay after deductible
	Brand Non-Formulary	$60 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay	$60 Copay after deductible	$60 Copay after deductible
	Mail Order (plus Retail 90-Days)	2.5 x Copay	Not Covered	2.5 x Copay	Not Covered	2.5 x Copay	Not Covered	2.5 x Copay	Not Covered
Financials		Proposed		Proposed		Proposed		Proposed	
	Single	$565.12		$552.69		$531.93		$468.06	
	2 Person	$1,271.52		$1,243.55		$1,196.84		$1,053.14	
	Family	$1,582.34		$1,547.53		$1,489.40		$1,310.57	

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Plan design subject to change due to Health Care Reform requirements. The illustrative rates include taxes and fees.

2015 Medical Marketing Report

WMHIP Plan Designs

		BCBSM PPO		BCBSM PPO		BCBSM PPO		BCBSM HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Design	**Deductible - Individual**	$250	$500	$500	$1,000	$250	$1,000	$1,300	$2,500
	Deductible - Family	$500	$1,000	$1,000	$2,000	$500	$2,000	$2,600	$5,000
	Out of Pocket Max - Individual ***(includes deductible)***	$6,600	$2,250	$6,600	$3,000	$6,600	$2,500	$2,250	$4,500
	Out of Pocket Max - Family ***(includes deductible)***	$13,200	$5,000	$13,200	$6,000	$13,200	$5,000	$4,500	$9,000
	Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
	Coinsurance	90%	70%	100%	80%	100%	80%	100%	80%
	Preventive Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
	PCP Office Visits	$20	70% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Specialist Office Visits	$20	70% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Urgent Care	$20	70% after deductible	$20	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Diagnostic Lab and X-Ray	90% after deductible	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Inpatient Mental Heath & Substance Abuse	90% after deductible	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Outpatient Mental Heath - *Physician's Office**	$20	70% after deductible	$20	80% after deductible	$20	80% after deductible	100% after deductible	80% after deductible
	Outpatient Substance Abuse*	$20	90% after deductible	$20	90% after deductible	$20	90% after deductible	100% after deductible	80% after deductible
	Chiropractic Services-limited to 24 visits except where noted	90% after deductible	80% after deductible	100%	80% after deductible	100%	80% after deductible	100% after deductible	80% after deductible
	Physical, Occupational and Speech Therapy- Limited to 60 combined visits per year	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Ambulance	90% after in-network deductible		100% after in-network deductible		100% after in-network deductible		100% after in-network deductible	
	Emergency Room	90% after in-network deductible $25 Copay for non-emergency use		Covered 100%, $25 Copay for non-emergency use		Covered 100%, $25 Copay for non-emergency use		100% after deductible, Not Covered for non-emergency	
	Generic	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay	Copay plus 25%	$10 Copay after deductible	Copay plus 25%
	Brand Formulary	$40 Copay		$40 Copay		$40 Copay		$40 Copay after deductible	
	Brand Non-Formulary								
	Mail Order (plus Retail 90-Days)	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered	2x Copay	Not Covered
Financials		Proposed		Proposed		Proposed		Proposed	
	Single	$485.38		$523.79		$539.01		$450.25	
	2 Person	$1,164.86		$1,257.04		$1,293.57		$1,080.56	
	Family	$1,456.11		$1,571.34		$1,616.99		$1,350.73	

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Plan design subject to change due to Health Care Reform requirements. The WMHIP rates include all state and federal taxes and fees.