2020 Employee Benefit Insurance Premiums
For the period January 1, 2020 through December 31, 2020

Full Time Employees

WMHIP Blue Cross PPO Select $500/$1000 Deductible Plan

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 789.23	$ 220.99	$ 110.50
Two Person	$ 1,775.72	$ 565.51	$ 282.76
Family	$ 2,209.82	$ 703.76	$ 351.88

WMHIP Versatile 3 PPO $250/$500 Deductible Plan w 90/10 co-insurance

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 721.89	$ 153.65	$ 76.82
Two Person	$ 1,624.21	$ 398.54	$ 199.27
Family	$ 2,021.26	$ 495.96	$ 247.98

WMHIP Flexible Blue $1400/$2800 Deductible Plan

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 669.64	$ 101.40	$ 50.70

Two Person	$ 1,506.66	$ 277.89	$ 138.95
Family	$ 1,874.79	$ 345.79	$ 172.90

WMHIP PPO 3 $1000/$2000 Deductible Plan w 80/20 co-insurance

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 634.03	$ 65.79	$ 32.89
Two Person	$ 1,426.53	$ 208.19	$ 104.09
Family	$ 1,775.08	$ 259.06	$ 129.53

WMHIP Essential HDHP $3000/$6000 Deductible Plan w 80/20 co-insurance

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 566.78	$ -	$ -
Two Person	$ 1,275.20	$ 44.39	$ 22.20
Family	$ 1,586.79	$ 55.24	$ 27.62

ACA Part Time Employees (available to PT employees working 75% of FT workload)

WMHIP Versatile 3 PPO $250/$500 Deductible Plan w 90/10 co-insurance

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 721.89	$ 211.39	$ 105.70
Two Person	$ 1,624.21	$ 1,113.72	$ 556.86

Family	$ 2,021.26	$ 1,510.77	$ 755.39

WMHIP Flexible Blue $1400/$2800 Deductible Plan

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 669.64	$ 159.15	$ 79.58
Two Person	$ 1,506.66	$ 996.17	$ 498.09
Family	$ 1,874.79	$ 1,364.30	$ 682.15

WMHIP Essential HDHP $3000/$6000 Deductible Plan w 80/20 co-insurance

Coverage	Full Monthly Premium	Employee Share of Monthly Premium	Employee Per Pay Period Deduction
Single	$ 566.78	$ 56.29	$ 28.14
Two Person	$ 1,275.20	$ 764.71	$ 382.36
Family	$ 1,586.79	$ 1,076.30	$ 538.15

Grandfathered Part Time Employees (eligible under previous healthcare agreement)

WMHIP Versatile 3 PPO $250/$500 Deductible Plan w 90/10 co-insurance

Coverage	Full Monthly Premium	Employer Share of Monthly Premium	Employee Share of Monthly Premium (grandfathered with subsidy)	With Subsidy Per Pay	Employee Share of Monthly Premium (grandfathered without subsidy)	Without Subsidy Per Pay
Single	$ 721.89	$ 348.58	$ 373.31	$ 186.66	$ 721.89	$ 360.95
Two Person	$ 1,624.21	$ 782.89	$ 841.32	$ 420.66	$ 1,624.21	$ 812.11

Family	$ 2,021.26	$ 975.49	$ 1,045.78	$ 522.89	$ 2,021.26	$ 1,010.63

WMHIP Flexible Blue $1400/$2800 Deductible Plan

Coverage	Full Monthly Premium	Employer Share of Monthly Premium	Employee Share of Monthly Premium (grandfathered with subsidy)	With Subsidy Per Pay	Employee Share of Monthly Premium (grandfathered without subsidy)	Without Subsidy Per Pay
Single	$ 669.64	$ 348.57	$ 321.07	$ 160.54	$ 669.64	$ 334.82
Two Person	$ 1,506.66	$ 782.89	$ 723.77	$ 361.88	$ 1,506.66	$ 753.33
Family	$ 1,874.79	$ 975.49	$ 899.30	$ 449.65	$ 1,874.79	$ 937.40

WMHIP Essential HDHP $3000/$6000 Deductible Plan w 80/20 co-insurance

Coverage	Full Monthly Premium	Employer Share of Monthly Premium	Employee Share of Monthly Premium (grandfathered with subsidy)	With Subsidy Per Pay	Employee Share of Monthly Premium (grandfathered without subsidy)	Without Subsidy Per Pay
Single	$ 566.78	$ 348.57	$ 218.21	$ 109.10	$ 566.78	$ 283.39
Two Person	$ 1,275.20	$ 782.89	$ 492.31	$ 246.16	$ 1,275.20	$ 637.60
Family	$ 1,586.79	$ 975.49	$ 611.30	$ 305.65	$ 1,586.79	$ 793.40

Dental & Vision Coverage (available for purchase by eligible PT employees)

Coverage	Full Monthly Dental Premium	Employee Dental Premium Share Per Pay Period	Full Monthly Vision Premium	Employee Vision Premium Share Per Pay Period
Single	$ 67.30	$ 33.65	$ 4.82	$ 2.41

COBRA (Continuation) Coverage

Coverage	WMHIP PPO Select	WMHIP PPO Versatile	WMHIP FlexBlue	WMHIP PPO Plan 3	WMHIP Essential HDHP
Single	$ 805.01	$ 736.33	$ 683.04	$ 646.71	$ 578.11
Two Person	$ 1,811.23	$ 1,656.70	$ 1,536.80	$ 1,455.06	$ 1,300.71
Family	$ 2,254.02	$ 2,061.69	$ 1,912.29	$ 1,810.58	$ 1,618.53

Coverage	Dental	Vision
Single	$ 68.65	$ 4.92
Two Person	$ 68.65	$ 9.33
Family	$ 68.65	$ 13.71