HealthPlans, Inc.

Summary of Benefits

Town of Webster – Network Plan

*Medical Benefits for Group **BP3** Effective 7/1/2019*

Covered Services	Tier 1	Tier 2	Tier 3
Deductible & Out-of-Pocket			
Annual Plan Year Deductible *Single* *Family*	 None None	 $250 $750	 $250 $750
Annual Out-of-Pocket Maximum *(includes Deductible, Co-Insurance, Copayments & Prescription Copayments)* *Single* *Family*	 $2,500 $5,000	 $2,500 $5,000	 $2,500 $5,000
Preventive Care			
Routine Physicals, Gynecological Exams & Family Planning	No Charge	No Charge	No Charge
Routine Hearing Exams & Routine Vision Exams *(one Vision Exam every 24 months)*	No Charge	No Charge	No Charge
Other Services			
Office Visit – Primary Care and Urgent Care	$20 copay	$20 copay	$20 copay
Office Visit – Specialist Care	$35 copay	$35 copay	$35 copay
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy *(up to 60 visits per Plan year for Occupational and Physical Therapy)*	$25 copay	$25 copay	$25 copay
Diagnostic Lab & X-Ray	No Charge	Deductible then no charge	Deductible then no charge
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests *(done in general hospitals per category, per service date)*	$100 copay	Deductible then $100 copay	Deductible then $100 copay
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests *(done by other covered providers)*	$100 copay	$100 copay	$100 copay
Ambulatory Surgical Facility per Admission	$150 copay	$150 copay	$150 copay
Inpatient Hospital & Surgical Day Care Unit per Admission	$300 copay	Deductible then $300 copay	Deductible then $700 copay
Mental Health Hospital or Substance Abuse Facility	$150 copay	$150 copay	$150 copay
Mental Health or Substance Abuse Treatment	$15 copay	$15 copay	$15 copay
Home Health Care and Hospice	No Charge	No Charge	No Charge
Emergency Room *(copay waived if admitted)*	$100 copay	$100 copay	$100 copay
Nurse Practitioner *(not billed by PCP)*	$15 copay	$15 copay	$15 copay
Fitness Reimbursement & Weight Loss Reimbursement	$150 per year each per category		
Prescription Drug Benefits			
Retail Pharmacy (*up to a 30-day supply)*	$10 (Generic) / $25 (Preferred Brand) / $50 (Non-Preferred Brand)		
Mail Order *(up to a 90-day supply)*	$20 (Generic) / $50 (Preferred Brand) / $110 (Non-Preferred Brand)		

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization. Hearing Aids up to $2,000 per ear every 36 months for a member age 21 or younger is covered by the Plan.