Town of Webster — PPO Plan

*Medical Benefits for Group **BP3** Effective 7/1/2024*

Covered Services	In-Network Providers	Out-of-Network Providers
Deductible & Out-of-Pocket		
Plan Year Deductible *Single* *Family*	 $250 $750	 $400 $800
Plan Year Out-of-Pocket Maximum *(includes Deductible coinsurance and copays)* *Single* *Family*	 $2,000 $4,000	 $3,000 per member
Preventive Care		
Routine Physicals, Gynecological Exams & Family Planning	No Charge	No Charge
Routine Hearing Exams & Routine Vision Exams *(one Vision Exam every 24 months)*	No Charge	No Charge
Other Services		
Office Visit – Primary Care and Urgent Care	$20 copay	Deductible then 20%
Office Visit – Specialist Care	$35 copay	Deductible then 20%
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy *(up to 60 visits per Plan year for Occupational and Physical Therapy and up to 20 visits per plan year for Chiropractic)*	$20 copay	Deductible then 20%
Diagnostic Lab & X-Ray	Deductible then no charge	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests *(done in general hospitals per category, per service date)*	Deductible then $100 copay	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests *(done by other covered providers)*	Deductible then $150 copay	Deductible then 20%
Ambulatory Surgical Facility per Admission	Deductible then $150 copay	Deductible then 20%
Inpatient Hospital & Surgical Day Care Unit per Admission	Deductible then $300 copay Deductible then $700 copay for certain hospitals	Deductible then 20%
Mental Health Hospital or Substance Abuse Facility	Deductible then $200 copay	Deductible then 20%
Mental Health or Substance Abuse Treatment	Deductible then $15 copay	Deductible then 20%
Home Health Care and Hospice	Deductible then no charge	Deductible then 20%
Emergency Room *(copay waived if admitted)*	$100 copay	$100 copay
Nurse Practitioner *(not billed by PCP)*	$20 copay	Deductible then 20%
Fitness Reimbursement & Weight Loss Reimbursement	$150 per year each per category	
Prescription Drug Benefits	**Express Scripts**	
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.