Town of Webster
2023 Healthcare Rates & Percentages

Plan choice and employee cost share depend on union contract/Town policy

All subject to change per CBA

CORE PLAN

	RATES		Bi-weekly Employee share				
	Annual	Monthly	5%	10%	15%	20%	25%
Single Plan	$11,033.64	$919.47	NA	$45.97	$68.96	$91.95	$114.93
2-Person PLAN	$24,826.44	$2,068.87	NA	$103.44	$155.17	$206.89	$258.61
Family Plan	$29,042.88	$2,420.24	NA	$121.01	$181.52	$242.02	$302.53

Plus HRA per Union Contract

HYBRID PLAN

	RATES		Bi-weekly Employee share				
	Annual	Monthly	5%	10%	15%	20%	25%
Single Plan	$9,760.08	$813.34	NA	$40.67	$61.00	$81.33	$101.67
2-Person PLAN	$21,960.96	$1,830.08	NA	$91.50	$137.26	$183.01	$228.76
Family Plan	$25,690.68	$2,140.89	NA	$107.04	$160.57	$214.09	$267.61

Plus HRA per Union Contract

HDHP

	RATES		Bi-weekly Employee share				
	Annual	Monthly	5%	10%	15%	20%	25%
Single Plan	$7,550.40	$629.20	$15.73	$31.46	$47.19	$62.92	$78.65
2-Person PLAN	$16,988.88	$1,415.74	$35.39	$70.79	$106.18	$141.57	$176.97
Family Plan	$19,874.16	$1,656.18	$41.40	$82.81	$124.21	$165.62	$207.02
Single Buy Up → 2-person	$9,438.48	$786.54	$409.00	$424.73	$440.46	$456.19	$471.92
Single Buy Up → Family	$12,323.76	$1,026.98	$513.49	$513.49	$513.49	$513.49	$513.49

Plus HSA deposits of $1,800 Single, $3,600 2-Person or Family

** 1st Year sign up receives an additional $500 DEPOSIT**

Blue Collar: 1st Year amount = $750. 2nd Year amount = $500

Benefit Highlight	2023 Town of Webster Medical Benefit Plans		
	Core Plan	Hybrid Plan	HDHP $1,800/$3,600
Primary Care Physician (PCP) Visit	$25	$30	20% Coinsurance after Deductible
PCP Sick Child Visits	Covered in Full, **$0 PCP visits to age 26**	Covered in Full, **$0 PCP visits to age 26**	20% Coinsurance after Deductible
Gia Telemedicine	**Covered in Full**	**Covered in Full**	**Covered in Full after Deductible**
Specialist Visit	$40	$50	20% Coinsurance after Deductible
Well Child Visits	Covered in Full	Covered in Full	Covered in full
Routine Physical Exams	Covered in Full	Covered in Full	Covered in Full
Routine Adult Immunization	Covered in Full	Covered in Full	Covered in Full
Routine Mammography	Covered in Full	Covered in Full	Covered in Full
Routine GYN Exam	Covered in Full	Covered in Full	Covered in Full
Routine Prostate Screening	Covered in Full	Covered in Full	Covered in Full
Routine Colonoscopy	Covered in Full	Covered in Full	Covered in Full
Allergy Tests/Injections	$25 PCP/$40 Specialist	$30 PCP/$50 Specialist	20% Coinsurance after Deductible
Chiropractic	$25	$30	20% Coinsurance after Deductible
Acupuncture	$40 copay, up to 10 visits/year	$50 copay, up to 10 visit/year	20% Coinsurance after Deductible
Diagnostic Lab	Covered in Full	Covered in Full	20% Coinsurance after Deductible
Diagnostic Lab (MVP Preferred Provider Facility)	Covered in Full	Covered in Full	**Covered in Full after Deductible (discounted fee schedule applies)**
Diagnostic X-Ray	$40	$50	20% Coinsurance after Deductible
Diagnostic X-Ray (MVP Preferred Provider Facility)	**Covered in Full**	**Covered in Full**	**Covered in Full after Deductible (discounted fee schedule applies)**
Maternity – Pre & Post	$50	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Maternity Hosp.	$300	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Inpatient Hosp.	$300	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Inpatient Surgery	20% or $300	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Anesthesia	Covered in Full	Covered in Full	20% Coinsurance after Deductible
Outpatient Surgery	Facility: $75 Physician: $40	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Surgery (MVP Preferred Provider Facility)	**Facility: Covered in Full Physician: $20**	**Covered in Full after Deductible (discounted fee schedule applies)**	**Covered in Full after Deductible (discounted fee schedule applies)**
Inpatient Mental Health	$300	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Mental Health	$25	$30	20% Coinsurance after Deductible
myVisitNow Mental Health	Covered in Full	Covered in Full	Covered in Full
Inpatient Substance Abuse	$300	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Substance Abuse	$25	$30	20% Coinsurance after Deductible
Rx- 30 day retail	$5/$30/$50, **$0 generic for kids to age 26**	$5/$35/$70, **$0 generic for kids to age 26**	10%/30%/50% Coinsurance after the deductible; **Preventive RX not subject to the deductible**
Routine Vision	$25/year	$30/year	Covered in Full per Year
Eyewear	$60 allowance/year	$60 allowance/year	Not covered
Emergency Room	$75	$150	20% Coinsurance after Deductible
Gia Telemedicine	**Covered in Full**	**Covered in Full**	**Covered in Full after Deductible**
Ambulance Services	$50	$100	20% Coinsurance after Deductible
Urgent Care	$25	$30	20% Coinsurance after Deductible
Chemotherapy	$25	$30	20% Coinsurance after Deductible
Radiation	$25	$30	20% Coinsurance after Deductible
Hospice	Covered in Full, up to 210 days/lifetime	Covered in Full, up to 210 days/lifetime	20% Coinsurance after Deductible up to 210 days per lifetime
Skilled Nursing Facility	$300, up to 120 days/year	20% Coinsurance after Deductible up to 120 days per year	20% Coinsurance after Deductible up to 120 days per year
Home Care	Covered in Full up to 60 visits per year	Covered in Full up to 60 visits per year	20% Coinsurance after Deductible up to 60 days per year
Durable Medical Equip.	20%	20%	20% Coinsurance after Deductible
Outpatient Physical, Speech, Occupational Therapy	$40, **unlimited visits**	$50, **unlimited visits**	20% Coinsurance after Deductible, **unlimited visits**
Cardiac & Pulmonary Rehabilitation (up to 36 visits per year)	**$0 Copay per provider, per date of service**	**$0 Copay per provider, per date of service**	**Covered in Full after Deductible**
Routine Hearing Exam	$40	$50	20% Coinsurance after Deductible
Dependent Age Limit	26	26	26
Network	National & **Preferred Network**	National & **Preferred Network**	National & **Preferred Network**
Referrals	Not Required	Not Required	Not Required
Deductible Individual/Family	N/A	$750 / $1,500 / $1,875	$1,800 / $3,600
Coinsurance	N/A	20%	20%
Out-of-Pocket Max Single/Family	$6,600 / $13,200	$3,000 / $6,000	$3,000 / $6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Wellness Rewards	**$600 Well Being Rewards**	**$600 Well Being Rewards**	**$600 Well Being Rewards**
Wondr Health Lifestyle Program	**Covered in Full**	**Covered in Full**	**Covered in Full**