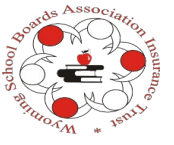


WSBAIT Benefit Plan Options-2021/2022



Medical	PLAN - B				PLAN - C				HDHP		HDHP		HDHP		HDHP	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Deductible Amount																
In-Network	\$1,000	\$2,000	\$2,500	\$5,000	\$2,800	\$5,600	\$5,000	\$10,000	30%		\$6,500	\$13,000				
Out-of-Network **	\$2,000	\$4,000	\$5,000	\$10,000	\$5,200	\$10,400	\$10,000	\$20,000	50%		\$13,000	\$26,000				
Dr. Office Co-Pay	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist	Primary	Specialist				
In-Network	\$40	\$75	\$40	\$75	Deductible & Co-Insurance		Deductible & Co-Insurance		30%	30%	Deductible & Co-Insurance					
Out-of-Network **	Non-Network Ded & Coins		Non-Network Ded & Coins		Deductible & Co-Insurance		Deductible & Co-Insurance		50%	50%	Deductible & Co-Insurance					
Rx Card	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred				
Generic	\$15	\$15	\$15	\$15	Deductible & Co-Insurance		Deductible & Co-Insurance		30%	30%	Deductible & Co-Insurance					
Brand Name	\$45	\$85	\$45	\$85	Deductible & Co-Insurance		Deductible & Co-Insurance		30%	30%	Deductible & Co-Insurance					
Specialty Rx	\$250		\$250		Deductible & Co-Insurance		Deductible & Co-Insurance		30%		Deductible & Co-Insurance					
Mail Order & Retail Pharmacy	3 x Monthly co-pay - 3 Month Supply		3 x Monthly co-pay - 3 Month Supply		Deductible & Co-Insurance		Deductible & Co-Insurance		3 x Monthly co-pay - 3 Month Supply		Deductible & Co-Insurance					
Hospital Co-Pay (per facility visit)	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient	In-Patient	Out-Patient				
In-Network	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
Out-of-Network **	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500	\$1,000	\$500				
Emergency Room Co-pay *	\$250		\$250													
Urgent Care Co-pay *	\$75		\$75													
<i>*True emergency apply to deductible/coinsurance. Non true emergency \$250 co-pay applied followed by deductible/coinsurance. \$250 applies to max out of pocket.</i>																
Co-Insurance (what happens after the Deductible Amount)																
In-Network Plan Pays	80%		80%		80%		80%		70%		100%					
Out-of-Network ** Plan Pays	50%		50%		50%		50%		50%		50%					
TOTAL Out-of-Pocket (including Deductible, Co-insurance, Office Visit and RX Co-Pays)																
In-Network (Single / Family)	\$6,500	\$13,000	\$6,500	\$13,000	\$3,500	\$7,000	\$5,500	\$11,000	\$7,150	\$14,300	\$6,500	\$13,000				
Out-of-Network ** (Single / Family)	\$12,000	\$24,000	\$13,000	\$26,000	\$7,200	\$15,000	\$12,000	\$24,000	\$14,300	\$28,600	\$14,300	\$28,600				

** Non-Network Out-of-Pocket Amount does NOT include amounts in excess of the "Allowable Medicare Reimbursement" PLUS 40%

Dental	(Available only if offered by your District)									
	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Deductible Amount	\$100	\$300	\$50	\$150	\$50	\$150	\$40	\$120	\$25	\$75
Preventative Care	80%	80%	100%	100%	100%	100%	100%	100%	100%	100%
Basic Care	50%	50%	80%	80%	80%	80%	80%	80%	80%	80%
Major Restorative	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontia	not covered	not covered	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontia Lifetime Max	not covered	not covered	\$1,000	\$1,000	\$2,000	\$2,000	\$3,000	\$3,000	\$4,000	\$4,000
Annual Max per Person	\$750	\$750	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000	\$3,000	\$3,000

This SUMMARY is not intended as a complete description of benefits and limitations of each of the Plans offered. Please refer to the Summary Plan Document(s) for a complete listing of covered and exclusions.