

WEBT

SUMMARY OF MEDICAL BENEFITS

****Applies to Medical OOP Maximum**

****Applies to Prescription Drugs OOP Maximum**

OOP = Out-of-Pocket

Medical Plan	<u>\$2,500</u>
**Office Visits	\$45 copay
Teladoc	\$0 copay
**Deductible	\$2,500 (\$5,000 family)
**Coinsurance	80%/20%
	Participant Liability: \$1,500 (\$3,000 family)
Medical OOP Maximum	\$4,000 (\$8,000 family)
**Prescription Drugs	Retail - for 30 day supply: Generic \$15 Listed Brand \$40 Non-Listed Brand \$60 Specialty Rx 20%
	Mail Order-for 90 day supply: Generic \$30 Listed Brand \$80 Non-Listed Brand \$120 Specialty Rx 20%
Prescription Drugs OOP Maximum	\$1,500 per calendar year out of pocket maximum per person

Please Note: PPACA limits the total annual in-network out of pocket maximum to \$9,450 per single contract and to \$18,900 per all other contracts.

In no circumstance will an individual enrollee within WEBT meet the PPACA total in-network out of pocket maximum of \$9,450.

This comparison of coverages is intended only as a general description of the benefit plans. Please refer to the Benefit Document for details.

WEBT
SUMMARY OF MEDICAL BENEFITS

Preventive Services	Unlimited Services as Defined by PPACA
In-Hospital Pre-Certification	Deductible + 20% Coinsurance Required for Non-Emergency, Non-Maternity Admissions
Surgery Hospital Inpatient Outpatient	Deductible + 20% Coinsurance
Physician's Office Ambulatory Surgical Center	Covered at 100% of Allowable Charges after Deductible
Laboratory/Pathology/X-Ray	Deductible + 20% Coinsurance
Magnetic Resonance Imaging (MRI)	Deductible + 20% Coinsurance
Work Related Injuries	Deductible + 20% Coinsurance
Therapy Physical Therapy Occupational Therapy Speech Therapy	Deductible + 20% Coinsurance - 30 Combined Visits per Illness or Injury
Spinal Manipulations	Deductible + 20% Coinsurance - 30 Visits per Calendar Year
Ambulance Ground Air	Deductible + 20% Coinsurance
Mental Health	Deductible + 20% Coinsurance
Substance Abuse	Deductible + 20% Coinsurance
Dependent Eligibility	End of Month Age 26
Dependent Maternity	Not Covered
Rehabilitation Services	Deductible + 20% Coinsurance for Specified Conditions that Meet Criteria
Plan Maximum	Unlimited

This comparison of coverages is intended only as a general description of the benefit plans. Please refer to the Benefit Document for details.