



## SUMMARY OF MEDICAL BENEFITS

**\*\*Applies to Medical OOP Maximum**

**\*\*Applies to Prescription Drug OOP Maximum**

**OOP = Out-of-Pocket**

<b>Benefit</b>	<b><u>\$1,500</u></b>
<b>**Office Visits</b>	\$40 Co-Pay
<b>**Teladoc</b>	\$0 Co-Pay
<b>**Deductible</b>	\$1,500 (\$3,000 Family)
<b>**Coinsurance</b>	80%/20%
<b>Medical OOP Maximum</b>	<u>In Network:</u> \$3,000 (\$6,000 Family) <u>*Out of Network:</u> \$3,300 (\$6,600 Family)
<b>**Prescription Drugs</b>	Retail - for 30 day supply:  Generic \$15 Preferred Brand \$40 Non-Preferred Brand \$60 Specialty Rx 20%  Mail Order - for 90 day supply:  Generic \$30 Preferred Brand \$80 Non-Preferred Brand \$120
<b>Prescription Drug OOP Maximum</b>	\$1,500 per calendar year out of pocket maximum per person

*\*Members may be balance billed for Out of Network.*

***Please Note: PPACA limits the total annual in-network out of pocket maximum to \$10,600 per single contract and to \$21,200 per all other contracts. In no circumstance will an individual enrollee within WEBT meet the PPACA total in-network out of pocket maximum of \$10,600.***



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<b>Preventive Services</b>	Unlimited Services as Defined by PPACA
<b>In-Hospital Pre-Certification</b>	Deductible + 20% Coinsurance Required for Non-Emergency, Non-Maternity Admissions
<b>Surgery Hospital Inpatient Outpatient</b>	Deductible + 20% Coinsurance
<b>Physician's Office Ambulatory Surgical Center</b>	Covered at 100% of Allowable Charges after Deductible
<b>Laboratory/Pathology/X-Ray</b>	Deductible + 20% Coinsurance
<b>Magnetic Resonance Imaging (MRI)</b>	Deductible + 20% Coinsurance
<b>Work Related Injuries</b>	Deductible + 20% Coinsurance
<b>Therapy Physical Therapy Occupational Therapy Speech Therapy</b>	Deductible + 20% Coinsurance - 30 Combined Visits per Illness or Injury
<b>Spinal Manipulations</b>	Deductible + 20% Coinsurance - 30 Visits per Calendar Year
<b>Ambulance Ground Air</b>	Deductible + 20% Coinsurance
<b>Mental Health</b>	Deductible + 20% Coinsurance
<b>Substance Abuse</b>	Deductible + 20% Coinsurance
<b>Dependent Eligibility</b>	End of Month Age 26
<b>Rehabilitation Services</b>	Deductible + 20% Coinsurance for Specified Conditions that Meet Criteria
<b>Plan Maximum</b>	Unlimited

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