

**WEBT**

**SUMMARY OF MEDICAL BENEFITS**

**\*\*Applies to Medical Out of Pocket Maximum**

<b>Medical Plan</b>	<b><u>\$1,650 HDHP</u></b>
<b>**Office Visits</b>	Deductible, then Coinsurance
<b>**Teladoc</b>	\$55 per visit
<b>**Deductible</b>	\$1,650 Single Contract Only \$3,300 All Other Contracts
<b>**Coinsurance</b>	80%/20%
<b>**Prescription Drugs</b>	Deductible, then Coinsurance
<b>Out of Pocket Maximum</b>	<u>In Network:</u> \$3,150 Single Contract Only \$6,300 All Other Contracts  <u>*Out of Network:</u> \$3,465 Single Contract Only \$6,930 All Other Contracts

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

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

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**SUMMARY OF MEDICAL BENEFITS**

<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

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