

WEBT

SUMMARY OF MEDICAL BENEFITS

****Applies to Medical OOP Maximum**

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

OOP = Out-of-Pocket

| | |
|---------------------------------------|--|
| Medical Plan | <u>\$3,500</u> |
| **Office Visits | \$50 copay |
| Teladoc | \$0 copay |
| **Deductible | \$3,500 (\$7,000 family) |
| **Coinsurance | 80%/20% |
| | Participant Liability: \$1,500 (\$3,000 family) |
| Medical OOP Maximum | \$5,000 (\$10,000 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 \$8,700 per single contract and to \$17,400 per all other contracts.

In no circumstance will an individual enrollee within WEBT meet the PPACA total in-network out of pocket maximum of \$8,700.

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

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|---|--|
| 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 | Deductible + 20% Coinsurance |
| Outpatient | |
| 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 |
| Rehabilitation Services | Deductible + 20% Coinsurance for Specified Conditions that Meet Criteria |
| Plan Maximum | Unlimited |

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