

## WEBT

### SUMMARY OF MEDICAL BENEFITS

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

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

OOP = Out-of-Pocket

<b>Medical Plan</b>	<b><u>\$1,000</u></b>
<b>**Office Visits</b>	\$35 copay
<b>Teladoc</b>	No cost
<b>**Deductible</b>	\$1000 (\$2000 family)
<b>**Coinsurance</b>	80%/20%
	Participant Liability: \$1500 (\$3000 family)
<b>**Medical OOP Maximum</b>	\$2500 (\$5000 family)
<b>**Prescription Drugs</b>	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%
<b>**Prescription Drugs OOP Maximum</b>	\$1500 per calendar year out of pocket maximum

**Please Note: PPACA limits the total annual in-network out of pocket maximum to \$7,350 per single contract and to \$14,700 per all other contracts.**

**In no circumstance will an individual enrollee within WEBT meet the PPACA total in-network out of pocket maximum of \$7,350.**

**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.**

**WEBT**  
**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) Initial on one day Additional on same day</b>	Deductible + 20% Coinsurance Limited to 50% of Allowable Charges
<b>Work Related Injuries</b>	Deductible + 20% Coinsurance
<b>Therapy Physical Therapy Occupational Therapy Speech Therapy</b>	Deductible + 20% Coinsurance - 30 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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