WEBT

SUMMARY OF MEDICAL BENEFITS

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

OOP = Out-of-Pocket

Medical Plan	**$1,500**	**$2,500**	**HDHP $3,500**
****Office Visits**	$40 copay	$45 copay	Deductible, then coinsurance
Teladoc	$0 copay	$0 copay	$50.00 per visit
****Deductible**	$1,500 ($3,000 family)	$2,500 ($5,000 family)	$3,500 ($7,000 family)
****Coinsurance**	80%/20%	80%/20%	80%/20%
	Participant Liability: $1,500 ($3,000 family)	Participant Liability: $1,500 ($3,000 family)	Participant Liability: $1,500 ($3,000 family)
Medical OOP Maximum	$3,000 ($6,000 family)	$4,000 ($8,000 family)	$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%	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%	Deductible, then coinsurance
Prescription Drugs OOP Maximum	$1,500 per calendar year out of pocket maximum per person	$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 $9,100 per single contract and to $18,200 per all other contracts.***

In no circumstance will an individual enrollee within WEBT meet the PPACA total in-network out of pocket maximum of $9,100.

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

Preventive Services	Unlimited Services as Defined by PPACA
In-Hospital	Deductible + 20% Coinsurance
Pre-Certification	Required for Non-Emergency, Non-Maternity Admissions
Surgery	
Hospital	
Inpatient	Deductible + 20% Coinsurance
Outpatient	
Physician's Office	Covered at 100% of Allowable Charges after Deductible
Ambulatory Surgical Center	
Laboratory/Pathology/X-Ray	Deductible + 20% Coinsurance
Magnetic Resonance Imaging (MRI)	Deductible + 20% Coinsurance
Work Related Injuries	Deductible + 20% Coinsurance
Therapy	
Physical Therapy	Deductible + 20% Coinsurance - 30 Combined Visits per Illness or Injury
Occupational Therapy	
Speech Therapy	
Spinal Manipulations	Deductible + 20% Coinsurance - 30 Visits per Calendar Year
Ambulance	
Ground	Deductible + 20% Coinsurance
Air	
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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