



BENEFIT	WELLNESS HMO PLAN
MAJOR MEDICAL *	Deductible: \$0 Individual / \$0 Family Coinsurance: Not Applicable Out-of-Pocket Max: \$1,500 per person; \$3,000 Two or More Members
LIFETIME MAXIMUM PER PERSON	No Lifetime Maximum
DOCTOR VISITS	\$20 Primary Care Physician Copay / \$40 Specialist Copay
IMMUNIZATIONS	Covered, No Charge
PREVENTIVE CARE FOR CHILDREN	Covered, No Charge
PREVENTIVE CARE FOR ADULTS	Covered, No Charge
OUTPATIENT X-RAY & LAB	Covered, \$10 Copay
RADIATION THERAPY, CHEMOTHERAPY	Radiation Therapy: Covered, No Charge Chemotherapy: Covered, \$40 Copay
DURABLE MEDICAL EQUIPMENT	Covered, No Charge In accord with DME Formulary
AMBULANCE-GROUND/AIR	Covered, \$100 Copay If Medically Necessary
PHYSICAL THERAPY	Covered, \$40 Copay

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CHIROPRACTIC	Not Covered	
ACUPUNCTURE	Covered, \$40 Copay Referral by Plan Physician	
HOSPITAL INPATIENT	Covered, \$500 Copay Per Admission Unlimited days, semi-private room	
HOSPITAL EMERGENCY ROOM	Covered, \$35 Copay (Waived if admitted as in-patient)	
HOME HEALTH CARE	Covered, No Charge (Up to 100 visits in a calendar year)	
HOSPICE	Covered, No Charge	
VISION EXAM	Covered, No Charge No frame, lens, contact allowance	
PRESCRIPTION DRUGS (CO-PAYMENTS)	<u>Retail</u> \$10 Generic \$25 Brand (30-day supply)	<u>Mail Order</u> \$20 Generic \$50 Brand (100-day supply)
<p>COPAY FOR INFERTILITY: 50% COPAY FOR ALLERGY INJECTIONS: \$5 This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits.</p>		