



# Exhibit 6 - BENEFIT SUMMARY

## Welborn / DEAC HMO

Effective January 1, 2009

Plan #W3949-A

**\* \* \* Vanderburgh County \* \* \*** Plan 1  
Deaconess Only

The Benefit Summary indicates WHP benefits, Member Copays, Coinsurance and Deductibles. The entire provisions of benefits and exclusions are contained in the Employer and Member Agreement. In the event of a conflict between the Agreement and this summary description, the terms of the Agreement will prevail.

### MEMBER SERVICES DEPARTMENT

(812) 426-6600 ♦ (800) 521-0265

### GENERAL BENEFIT LIMITS

Benefit Limit Per Lifetime (Excluding Organ & Tissue Transplants) (limited to \$1,000,000 per contract year)	\$5,000,000
Deductible Per Calendar Year	~ NONE ~
Out-of-Pocket Maximum	~ NONE ~

### PHYSICIAN OFFICE SERVICES (PCP/REFERRED SPECIALIST)

Office Visits to PCP, PA or NP	100% Coverage after \$10 Copay per visit
Office Visits to Specialist, PA or NP	100% Coverage after \$10 Copay per visit
Allergy Injections	100% Coverage after \$5 Copay
Immunizations & Injectable Medications	100% Coverage
Durable Medical Equipment and Medical Supplies	80% Coverage
Laboratory, X-Ray and other Diagnostic Services	100% Coverage
Office Surgery	100% Coverage
Chiropractic Services (Maximum Benefit Per Contract Year = \$750)	100% Coverage after \$10 Copay
Selected Benign Lesion Removal	50% Coverage after \$10 Copay

### EMERGENCY/URGENT CARE<sup>2</sup>

Emergency Room (ER) Services	100% Coverage after \$50 Copay
Urgent Care Center	100% Coverage after \$25 Copay
Ambulance Services (If Medically Necessary):	
♦ Ground Transportation	100% Coverage after \$50 Copay
♦ Air/Water Transportation	100% Coverage after \$250 Copay

<sup>2</sup>Emergency and Out-of-Area Urgent Care is Covered anywhere. Members must notify WHP within 48 hours. In-Area Urgent Care is Covered through the Member's PCP. ER Copay is waived if Member is hospitalized from ER.

### INPATIENT (HOSPITAL & OTHER PROVIDERS)

Hospital: Semi-Private Room and Ancillary Services	100% Coverage after \$100 Copay per Admission
Physician, PA and NP Services	100% Coverage
Alcohol and Drug Detoxification	100% Coverage after \$100 Copay per Admission
Skilled Nursing Facility (SNF) Services	100% Coverage after \$100 Copay per Admission

Maximum SNF Benefit Per Condition = 100 Days

### OUTPATIENT (HOSPITAL & OTHER PROVIDERS)

Hospital and Other Facility Services	100% Coverage
Physician, PA and NP Services	100% Coverage
Laboratory, X-Ray & Other Diagnostic Services	100% Coverage
Office Surgery	100% Coverage
Selected Benign Lesion Removal	50% Coverage
Alcohol and Drug Detoxification	100% Coverage
Durable Medical Equipment and Medical Supplies	80% Coverage
Radiation Therapy Services	100% Coverage
Rehabilitation Therapy Services	
♦ Physical and Occupational	100% Coverage after \$10 Copay per visit
	<i>Physical and Occupational Therapy is limited to a maximum of 40 combined visits per contract year</i>
♦ Speech	100% Coverage after \$10 Copay per visit
	<i>Speech Therapy is limited to a maximum of 20 visits per contract year</i>
♦ Cardiac and Pulmonary Rehab	100% Coverage after \$10 Copay per visit
	<i>Cardiac and Pulmonary Rehab Therapy is limited to a maximum of 24 visits each per contract year</i>
Skilled Home Health and Hospice Services	100% Coverage

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**RIDERS (only if applicable)**

For a detailed description of Covered Services, refer to the applicable Rider.

**RIDER 1: PRESCRIPTION DRUGS**

Coverage is for generic medication only. If generic is available and Member or Physician requests brand, Member pays applicable brand Copay plus the difference in cost between brand and generic drug. Some drugs may require prior authorization and may have quantity limits. Please see your Agreement and the Selected Pharmaceutical List (SPL) for additional information.

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
<b>Standard 30 day supply/refill</b>			
-Copay	\$10	\$20	\$30
<b>31-60 day supply</b>			
-Copay	\$16	\$32	\$48
<b>61-90 day supply</b>			
-Copay	\$24	\$48	\$72

**RIDER 2: ROUTINE VISION SERVICES**

Vision Exam.....One exam every 12 months with \$10 Copay  
 Primary Eye Care Services.....100% Coverage after \$10 Copay

**RIDER 4: ORGAN AND TISSUE TRANSPLANTS**

Selected Organ & Tissue Transplants.....100% Coverage after \$100 Copay per Admission  
 Transportation and Lodging.....Coverage up to \$10,000

*Maximum Benefit per Member per Contract Year = \$1,000,000*

*Medical Director approval is required prior to receiving any Transplant Service.*

**RIDER 5: MENTAL HEALTH/CHEMICAL DEPENDENCY**

**Mental Health Coverage**  
 Inpatient Professional & Facility.....100% Coverage after \$100 Copay per Admission  
 Outpatient Professional and Facility.....100% Coverage  
 Individual or Group Therapy Office Visits.....100% Coverage after \$10 Copay per visit

**Chemical Dependency Coverage**  
 Inpatient Professional & Facility.....100% Coverage after \$100 Copay per Admission  
 Outpatient Professional and Facility.....100% Coverage after \$25 Copay per day  
 Individual Therapy Office Visits.....100% Coverage after \$20 Copay per visit  
 Group Therapy Office Visits.....100% Coverage after \$10 Copay per visit

*Maximum Chemical Dependency Benefit per Contract Year =  
 14 Inpatient Days & 20 Office Visits*

*Services for substance abuse and chemical dependency, when required in the treatment of a mental illness, will be provided at the same benefit level as other medical or surgical conditions.*

**Chemical Dependency Chart:**

\*\* Chemical Dependency days and visits can be altered as follows:

1 Inpatient Day = 2 Outpatient Days  
 1 Individual Office Visit = 2 Group Therapy Office Visits

**RIDER 8: INFERTILITY**

Selected Inpatient and Outpatient Services:  
 ♦ Professional and Facility.....50% Coverage  
 ♦ Selected Infertility Drugs.....50% Coverage

*Member Coinsurance for Infertility services does not apply to Out-of-Pocket Maximum*

**RIDER 10: MATERNITY SERVICES**

Inpatient Professional and Facility Services.....100% Coverage after \$100 Copay per Admission  
 Outpatient Professional and Facility Services.....100% Coverage  
 Office Visits to PCP, Specialist, PA or NP.....100% Coverage after \$10 Copay per visit

PA – Physician Assistant      NP – Certified Nurse Practitioner