



Exhibit 6 - BENEFIT SUMMARY

Welborn / Enhanced POS

Effective January 1, 2009

Plan #P5581

* * * Vanderburgh County * * *
 POS Enhanced

Plan 3

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	IN-PLAN	OUT-OF-PLAN ⁵
Benefit Limit Per Lifetime (<i>Excluding Organ & Tissue Transplants</i>).....	----- \$5,000,000 ----- <i>(limited to \$1,000,000 per contract year)</i>	
Deductible Per Calendar Year.....	\$250/person ¹ \$500/family	\$500/person \$1,000/family
Out-of-Pocket Maximum Per Year (<i>Deductible applies to Out-of-Pocket Maximum</i>)	\$1,000/person ² \$2,000/family	\$2,000/person ³ \$4,000/family
Prior Authorization.....	Participating Provider Responsibility	Member responsibility (See explanation below) ⁴
Claims.....	Participating Providers submit claims	Member responsibility submit to WHP within 90 days
Excess Charges.....	None – Participating Providers accept WHP’s Usual & Customary Fees	Member is responsible for ⁵ charges exceeding WHP’s Usual & Customary fees
Pre-Existing Conditions.....	Not applicable	Not applicable

- ♦ **PREVENTIVE CARE** includes an annual physical exam, routine immunizations to age 18, routine pap smears, screening mammograms, colonoscopy screening and prostate screening, as well as routine lab and x-ray associated with an annual physical exam.
- 1. Deductible must be met before Plan pays medical benefits with the exception of Office Visits, Preventive Care including associated Lab/X-ray, ER and Urgent Care Visits, Allergy Injections, Immunizations and Injectables, and Office Surgery services.
- 2. The IN-PLAN Out-of-Pocket Maximum does not apply to Member payments for the following Covered Services: fixed dollar Copay (e.g., \$10). Applicable Copay is still required for such services after the Out-of-Pocket Maximum is satisfied.
- 3. The OUT-OF-PLAN Out-of-Pocket Maximum does not apply to Member payments for the following Covered Services: Copay for Rider services (if any), Member payments for excess charges and any Prior Authorization penalties. Such Member payments are still required after the Out-of-Pocket Maximum is satisfied.
- 4. Prior Authorization is required 48 hours in advance for all elective OUT-OF-PLAN hospitalizations, surgery in a surgical facility, home health/hospice services and Durable Medical Equipment purchases that exceed \$300. Failure to obtain Prior Authorization for Medically Necessary services results in a \$250 penalty per occurrence. Services that do not meet medical necessity are not Covered. When the Prior Authorization penalty is applied, WHP pays eligible charges less the \$250 penalty, less any applicable Copays and Deductibles. For Prior Authorization your Provider must call WHP’s Prior Authorization Department at 812-426-6600 or 800-521-0265.
- 5. Plan payment for OUT-OF-PLAN Covered Services applies to WHP’s Usual and Customary (U&C) fee schedule, and WHP Members are responsible for applicable Copays and Deductibles plus any charges exceeding WHP’s U&C fee schedule.

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PHYSICIAN OFFICE (PCP/REFERRED SPECIALIST)	IN-PLAN	OUT-OF-PLAN
Office Visits to PCP, PA or NP.....	100% Coverage after \$10 Copay per visit	70% Coverage after Deductible
Office Visits to Specialist, PA or NP.....	100% Coverage after \$10 Copay per visit	70% Coverage after Deductible
Allergy Injections.....	100% Coverage after \$5 Copay per visit	70% Coverage after Deductible
Immunizations & Injectable Medications.....	100% Coverage	70% Coverage after Deductible
Durable Medical Equipment & Medical Supplies.....	80% Coverage after Deductible	70% Coverage after Deductible
Laboratory, X-Ray & Other Diagnostic Services.....	100% Coverage	70% Coverage after Deductible
Office Surgery.....	100% Coverage	70% Coverage after Deductible
Chiropractic Services (<i>Maximum Benefit Per Contract Year = \$750</i>)	100% Coverage after Office Visit Copay per visit	70% Coverage after Deductible
Selected Benign Lesion Removal.....	50% after Office Visit Copay per visit and Deductible	Not Covered

EMERGENCY/URGENT CARE⁶

Emergency Room (ER) Services.....	100% Coverage after \$75 Copay	Covered under IN-PLAN Benefits
Urgent Care Center		
♦ Out-of-Area.....	N/A	100% Coverage after \$35 Copay
♦ In-Area.....	100% Coverage after \$35 Copay	70% Coverage after Deductible
Ambulance Services (If Medically Necessary)		
♦ Ground Transportation.....	90% after \$50 Copay and Deductible	Covered under IN-PLAN Benefits
♦ Air/Water Transportation.....	90% Coverage after \$250 Copay and Deductible	Covered under IN-PLAN Benefits

⁶Emergency 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.

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INPATIENT (HOSPITAL & OTHER PROVIDERS)

Hospital: Semi-Private Room and Ancillary Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Physician, PA and NP Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Alcohol and Drug Detoxification.....	90% Coverage after Deductible	70% Coverage after Deductible
Skilled Nursing Facility (SNF) Services..... <i>Maximum SNF Benefit Per Condition = 100 Days</i>	90% Coverage after Deductible	70% Coverage after Deductible

OUTPATIENT (HOSPITAL & OTHER PROVIDERS)

Hospital and Other Facility Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Physician, PA and NP Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Laboratory, X-Ray & Other Diagnostic Services.....	90% Coverage	70% Coverage after Deductible
Office Surgery.....	90% Coverage after Deductible	70% Coverage after Deductible
Selected Benign Lesion Removal.....	50% Coverage after Deductible	Not Covered
Alcohol and Drug Detoxification.....	90% Coverage after Deductible	70% Coverage after Deductible
Durable Medical Equipment and Medical Supplies.....	80% Coverage after Deductible	70% Coverage after Deductible
Radiation Therapy Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Rehabilitation Therapy Services:	90% Coverage after \$10 Copay per visit and Deductible	70% Coverage after Deductible
♦ Physical and Occupational..... <i>Physical and Occupational Therapy is limited to a maximum of 40 combined visits per contract year</i>	90% Coverage after \$10 Copay per visit and Deductible	70% Coverage after Deductible
♦ Speech..... <i>Speech Therapy is limited to a maximum of 20 visits per contract year</i>	90% Coverage after \$10 Copay per visit and Deductible	70% Coverage after Deductible
♦ Cardiac and Pulmonary Rehab..... <i>Cardiac and Pulmonary Rehab Therapy is limited to a maximum of 24 visits each per contract year</i>	90% Coverage after \$10 Copay per visit and Deductible	70% Coverage after Deductible
Skilled Home Health and Hospice Services.....	90% Coverage after Deductible	70% Coverage after Deductible

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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>
Standard 30 day supply/refill			
-Copay	\$10	\$20	\$30
61-90 day supply			
-Copay	\$20	\$40	\$60

RIDER 2: ROUTINE VISION SERVICES

Vision Exam.....	One exam every 12 months after \$10 Copay	Not Covered
Primary Eye Care Services.....	100% Coverage after \$10 Copay	Not Covered

RIDER 4: ORGAN AND TISSUE TRANSPLANTS

Organ & Tissue Transplant Services.....	90% Coverage after Deductible	Not Covered
Transportation and Lodging.....	Coverage up to \$10,000	Not Covered
<i>Maximum Benefit Per Member Per Contract Year = \$1,000,000</i>		
<i>Medical Director approval is req'd prior to receiving any Transplant service.</i>		

RIDER 5: MENTAL HEALTH/CHEMICAL DEPENDENCY

Mental Health		70% Coverage after Deductible
Inpatient Professional and Facility.....	90% Coverage after Deductible	Deductible
Outpatient Professional and Facility.....	90% Coverage after Deductible	70% Coverage after Deductible
Individual or Group Therapy Office Visits.....	100% Coverage after \$10 Copay per visit	70% Coverage after Deductible

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Chemical Dependency	90% Coverage after \$50 Copay per day and Deductible	50% Coverage after Deductible
Inpatient Professional and Facility.....		
Outpatient Professional and Facility.....	90% Coverage after \$25 Copay per day and Deductible	50% Coverage after Deductible
Individual Therapy Office Visits.....	100% Coverage after \$20 Copay per visit	50% Coverage after Deductible
Group Therapy Office Visits.....	100% Coverage after \$10 Copay per visit	50% Coverage after Deductible

*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 after Deductible	Not Covered
♦ Selected Infertility Drugs.....	50% Coverage after Deductible	Not Covered
<i>Member Coinsurance for Infertility services does not apply to Out-of-Pocket Maximum</i>		

RIDER 10: MATERNITY SERVICES

Inpatient Professional & Facility Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Outpatient Professional & Facility Services.....	90% Coverage after Deductible	70% Coverage after Deductible
Office Visit to PCP, PA or NP.....	100% Coverage after \$10 Copay per visit	70% Coverage after Deductible
Office Visit to Specialist, PA or NP.....	100% Coverage after \$10 Copay per visit	70% Coverage after Deductible