WELLPREMIUM™

The WellPREMIUM™ Plan provides coverage for the preventive health services required by the PHSA § 2713 (a) without any cost sharing requirements. All covered In Network preventive service will be 100% covered by the Plan. Out of Network services will not be covered unless otherwise specified, and the Plan Member will owe 100% of the cost of these services.

Deductible and Out of Pocket		
In Network Services	**Deductible**	**Out of Pocket Maximum**
Individual	$0	$8,550
Family	$0	$17,100

Overview of Benefits			
Medical Service	**Participating Providers** (In Network)	**Non-Participating Providers** (Out of Network)	**Limitations & Exclusions**
	Member Pays		
Preventive & Wellness Services	$0 Copay (Plan pays 100% of covered preventive and wellness services)	Not Covered -100% paid by Member	Some services are subject to age and other limitations. Not covered if services are provided at a hospital.
Primary Care Office Visit	$35 Copay Existing Doctor $70 Copay New Doctor	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Specialist Office Visit	$75 Copay Existing Doctor $150 Copay New Doctor	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Laboratory Service	$50 Copay per panel tested	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Radiology	$50 Copay per image billed	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
CT/MRI/MRA/PET Scan	$500 Copay per image billed	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Urgent Care	$75 Copay	Not Covered -100% paid by Member	Not covered if services are provided at a hospital.
Inpatient Room & Board	Not Covered -100% paid by Member	Not Covered -100% paid by Member	(Including Mental & Behavioral Health or Substance Abuse)
Other Inpatient Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Emergency Room Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Rehabilitation/Habilitation Services	Not Covered -100% paid by Member	Not Covered -100% paid by Member	Not covered
Pharmacy Benefits - (Subject to Formulary)			
Preventive Prescription Services	Generic - $0 Copay (Limited to Preventive Generic)	Not Covered -100% paid by Member	Limited to recommended preventive care as outlined by the Patient Protection & Affordable Care Act
ARRIVERX Pharmacy Program	Tier 1 = $0 Participant Payment (Over 200 Drugs) Tier 2 = $10 Participant Payment (Or less) Tier 3 = $25 Participant Payment (Over 600 Drugs) Tier 4 = $50 Participant Payment (Or less)		Drugs can be obtained at payments ranging from $0 to $50

NOTE:

- **Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.**
- **Refer to the Schedule of Benefits or ARRIVERX Product Flyer, as applicable, for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits or ARRIVERX Product Flyer, the Schedule of Benefits or ARRIVERX Product Flyer, as applicable, will govern.**