EASE | Health Plans

CARE AND HELP MEDICAL PLAN COMPARISON

Benefit Summary	WELLMEC™	WELLPREMIUM™	WELLESSENTIALS 2.5Rx™	WELLPLUS 20MP™
PREVENTIVE BENEFITS	Included	Included	Included	Included
TELEMEDICINE	$0 Consult Fee	$0 Consult Fee	$0 Consult Fee	$0 Consult Fee
DEDUCTIBLE				
Individual	$0	$0	$2,500	$1,000
Family	$0	$0	$5,000	$2,000
OUT-OF-POCKET MAX				
Individual	N/A	$9,100	$9,100	$9,100
Family	N/A	$18,200	$18,200	$18,200
MEDICAL SERVICES				
Doctor Visit Existing Doctor - Copay	Not Covered	$35	$50	$15
Doctor Visit New Doctor - Copay	Not Covered	$70	$150	$15
Specialist Visit Existing Doctor – Copay	Not Covered	$75	$100	$25
Specialist Visit New Doctor - Copay	Not Covered	$150	$200	$25
Outpatient Labs – Copay	Not Covered	$50	$50	$50
Outpatient X-Ray - Copay	Not Covered	$50	$75	$50
Outpatient (CT, MRI, PET Scans) – Copay	Not Covered	$500 (Limit 1)	$500	$400
Outpatient Surgery Facility Fees	Not Covered	Not Covered	Not Covered	Not Covered
Urgent Care – Copay	Not Covered	$75	$150	$100
Emergency Room - Copay	Not Covered	Not Covered	$400 after Deductible	$400 - Per Admission
Emergency Room Coinsurance	Not Covered	Not Covered	50% coinsurance after Deductible Limit to 1 visit per plan year	25% Coinsurance after Deductible
Hospital Room & Board - Copay	Not Covered	Not Covered	$500 after Deductible	$500 - Combined limit of 5 days.
Hospital Room & Board Coinsurance	Not Covered	Not Covered	50% coinsurance after Deductible Combined limit of 3 days	60% Coinsurance after Deductible
Generic Drugs - Copay	$0 Copay (Limited to preventive only)	$0 Copay (Limited to preventive only)	$0 Copay (Limited to preventive only)	$0 Copay (Limited to preventive only)
Prescription Benefits	Not Covered	Tier 1 = $0 (Over 200 Drugs) Tier 2 = $10 (Or less) Tier 3 = $25 (Over 600 Drugs) Tier 4 = $50 (Or less)	Tier 1 = $0 (Over 200 Drugs) Tier 2 = $10 (Or less) Tier 3 = $25 (Over 600 Drugs) Tier 4 = $50 (Or less)	Tier 1 = $0 (Over 200 Drugs) Tier 2 = $10 (Or less) Tier 3 = $25 (Over 600 Drugs) Tier 4 = $50 (Or less)

Note: Please refer to the schedule of benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern. For WELL MIN, deductible must be met before coverage applies.

Care & Help Home Care, LLC	
WELLMEC™	**Employee Weekly Cost**
EE Only	$ 3.42
EE + Spouse	$ 12.91
EE + Children	$ 11.86
EE + Family	$ 21.12
WELLPREMIUM™	**Employee Weekly Cost**
EE Only	$ 17.12
EE + Spouse	$ 32.49
EE + Children	$ 35.23
EE + Family	$ 50.93
WELLESSENTIALS 2.5Rx™	**Employee Weekly Cost**
EE Only	$ 50.34
EE + Spouse	$ 91.26
EE + Children	$ 94.09
EE + Family	$ 131.57
WELLPLUS 20MP™	**Employee Weekly Cost**
EE Only	$ 65.28
EE + Spouse	$ 113.09
EE + Children	$ 117.66
EE + Family	$ 158.49