

**2009
Medicare Advantage PFFS Plans
Comparison Chart**

Company	Advantra Freedom	Advantra Freedom	Anthem Blue Cross	Anthem Blue Cross
Plan Name	Freedom 2 Plan	Freedom 3 Plan	Smart Value Classic	Smart Value Plus
Telephone Numbers Website	New enrollment: 1-800-711-1607 Current members: 1-866-386-2330 advantrafreedom.com	New enrollment: 1-800-711-1607 Current members: 1-866-386-2330 advantrafreedom.com	New enrollment: 1-888-211-9813 Current members: 1-888-445-8916 anthem.com/ca	New enrollment: 1-888-211-9813 Current members: 1-888-445-8916 anthem.com/ca
Plan Type	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Includes Prescription Drug Benefit. May use any provider that accepts the plan's payment.
Monthly Premium	\$35 Monthly Premium. \$3000 out-of-pocket limit. Contact the plan for services that apply.	\$23 Monthly Premium. \$3,350 out-of-pocket limit. Contact the plan for services that apply.	\$0 Monthly Premium. \$4000 out-of-pocket limit. Contact the plan for services that apply.	\$0 Monthly Premium. \$4000 out-of-pocket limit. Contact the plan for services that apply.
Doctor Visit	\$15-\$50 each visit	\$20-\$50 each visit	\$15 each visit	\$20 each visit
Specialist Visit	\$30 each visit	\$30 each visit	\$25 each visit	\$30 each visit
Physician Network	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment
In-patient Hospitalization	\$180/day, days 1-5. \$0/day, days 6-90. \$0/day any additional days. Unlimited days each benefit period.	\$265/day, days 1-11. \$0/day, days 12-90. \$0/day any additional days. Unlimited days each benefit period.	\$200/day, days 1-5. \$0/day, days 6-90. \$1000 out of pocket limit per year. Unlimited days each benefit period.	\$275/day, days 1-5. \$0/day, days 6-90. \$1375 out of pocket limit per year. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-3. \$80/day, days 4-37. \$0/day, days 38-100. No prior hospital stay required. 100 days each benefit period.	\$100/day, days 1-25. \$0/day, days 26-100. No prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$125/day, days 21-100. No prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$125/day, days 21-100. No prior hospital stay required. 100 days each benefit period.
In-patient Mental Health	\$180/day, days 1-5. \$0/day, days 6-90. 190-day psychiatric hospital lifetime limit.	\$260/day, days 1-8. \$0/day, days 9-90. 190-day psychiatric hospital lifetime limit.	\$200/day, days 1-5. \$0/day, days 6-90. \$1000 out of pocket limit per year. 190-days psychiatric hospital lifetime limit.	\$275/day, days 1-5. \$0/day, days 6-90. \$1375 out of pocket limit per year. 190-days psychiatric hospital lifetime limit.
Outpatient Mental Health	\$30 each session	\$40 each session	50% each session	50% each session
Outpatient Services/Surgery	\$90 each visit	\$200 each visit	\$25-\$175 each visit depending on facility.	\$30-\$200 each visit depending on facility.
Ambulance	\$150 each service, waived if admitted.	\$150 each service, waived if admitted.	\$100 each service	\$150 each service
Emergency Room Visit	\$50 each visit, waived if admitted.	\$50 each visit, waived if admitted.	\$50 each visit, waived if admitted.	\$50 each visit, waived if admitted.
Outpatient Rehabilitation Services	\$30 each visit	\$35 each visit	\$25 each visit	\$30 each visit
Durable Medical Equipment	20% copay for each Medicare covered item.	20% copay for each Medicare covered item.	30% of the cost of each Medicare-covered item.	30% of the cost of each Medicare-covered item.
Diagnostic Tests, X-Rays, and Lab Services	\$5 each lab service, \$5 for diagnostic services. \$15-\$110 each X-ray. \$15-\$150 each diagnostic radiology. 20% for therapeutic radiology.	\$5 each lab service. \$5 for diagnostic services. \$35-\$200 for X-rays. \$35-\$200 for diagnostic radiology. 20% for therapeutic radiology.	\$15 each lab service. \$15-\$100 copays for diagnostic services, X-rays and diagnostic radiology. 20% of the cost for therapeutic radiology.	\$20 each lab service. \$20-\$100 for diagnostic services. \$30-\$100 each X-ray. \$30-\$100 for diagnostic radiology. 20% of the cost for therapeutic radiology.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	\$30 copay for Medicare-covered services. 50% of the cost for 1 exam and cleaning every 6 months. 50% of the cost for 1 X-ray per year.	\$30 copay for Medicare-covered services. 50% of the cost for 1 exam and cleaning every 6 months. 50% of the cost for 1 X-ray per year.	Preventative services not covered. \$0 copay for Medicare-covered service.	Preventative services not covered. \$0 copay for Medicare-covered service.
Hearing Services	\$0 copay for hearing aids up to \$100 limit per year. \$30 copay for diagnostic exams. \$30 copay for up to 1 routine test per year.	\$0 copay for hearing aids up to \$100 limit per year. \$30 copay for diagnostic exams. \$30 copay for up to 1 routine test per year.	You pay 100% of the cost of hearing aids. \$25 copay for diagnostic exam. \$25 copay for up to 1 routine test per year.	You pay 100% of the cost of hearing aids. \$30 copay for diagnostic exam. \$30 copay for up to 1 routine test per year.
Vision Services	20% for eye wear if after cataract surgery. \$30 copay for diagnostic exams. \$30 copay for up to 1 routine test per year. 0% of the cost of eye wear. \$100 limit for eyewear per year.	20% for eye wear after cataract surgery. \$30 for diagnostic exams and treatment to conditions. \$30 for up to 1 routine test per year. 0% of the cost of eye wear. \$100 limit for eyewear per year.	\$0 for 1 pair of glasses or contacts after cataract surgery. \$0 for 1 pair of glasses and contacts every 2 yrs. \$50 limit for eye wear every 2 yrs. \$25 copays for exams to diagnostic and treat conditions. \$25 copay for 1 routine exam per yr.	\$0 for 1 pair of glasses or contacts after cataract surgery. \$0 for 1 pair of glasses and contacts every 2 yrs. \$50 limit for eye wear every 2 yrs. \$30 copays for exams to diagnostic and treat conditions. \$30 copay for 1 routine exam per yr.
Miscellaneous	Nursing Hotline, Written education materials	Nursing Hotline, Written education materials	Nursing Hotline	Nursing Hotline
Prescription Drugs	No Prescription Drug benefit with this plan.	No Prescription Drug benefit with this plan.	No Prescription Drug benefit with this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.

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Company	Universal American	Universal American	Universal American	Universal American
Plan Name	Today's Options Value by CCRx	Today's Options Value	Today's Options Premier by CCRx	Today's Options Premier
Telephone Numbers Website	New enrollment: 1-866-234-3801 Current members: 1-866-222-5137 todaysoptionsccrx.com	New enrollment: 1-800-996-8867 Current Members: 1-866-568-8921 todaysoptions.com	New enrollment: 1-800-996-8867 Current Members: 1-866-568-8921 todaysoptions.com	New enrollment: 1-800-996-8867 Current Members: 1-866-568-8921 todaysoptions.com
Plan Type	PRIVATE FEE FOR SERVICE Includes Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Includes Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.
Monthly Premium	\$71.70 Monthly Premium. \$3000 out-of-pocket limit per year. Contact the plan for services that apply.	\$50 Monthly Premium. \$3000 out-of-pocket limit per year. Contact the plan for services that apply.	\$138.50 Monthly Premium. \$2500 out-of-pocket limit per year. Contact the plan for services that apply.	\$89 Monthly Premium \$2500 Out-of-pocket limit per year. Contact plan for services that apply.
Doctor Visit	In Network: \$20-\$35 Out of Network: \$20	In Network: \$20-\$35 Out of Network: \$20	In Network: \$10-\$35 Out of Network: \$10	In Network: \$10-\$35 Out of Network: \$10
Specialist Visit	In Network and Out: \$35	In Network and Out: \$35	In Network and Out: \$25	In Network and Out: \$25
Physician Network	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment
In-patient Hospitalization	In Network: \$195/day, days 1-5. \$0/day, days 6-90. Unlimited days covered each benefit period. Out: \$195/day, days 1-5. \$0/day, days 6-90.	In Network: \$195/day, days 1-5. \$0/day, days 6-90. Unlimited days covered each benefit period. Out: \$195/day, days 1-5. \$0/day, days 6-90.	In Network: \$350 each Medicare-covered stay. \$875 out-of-pocket limit per year. Unlimited days each benefit period. Out: \$350 each hospital stay.	In Network: \$350 each Medicare-covered stay. \$875 out-of-pocket limit per year. Unlimited days each benefit period. Out: \$350 each hospital stay.
Skilled Nursing Facility	In Network: \$0/day, days 1-20. \$100/day, days 21-100. No prior hospital stay required. 100 days each benefit period. Out: \$0/day, days 1-20. \$100/day, days 21-100.	In Network: \$0/day, days 1-20. \$100/day, days 21-100. No prior hospital stay required. 100 days each benefit period. Out: \$0/day, days 1-20. \$100/day, days 21-100.	In Network: \$0/day, days 1-20. \$100/day, days 21-100. No prior hospital stay required. 100 days each benefit period. Out: \$0/day, days 1-20. \$100/day, days 21-100.	In Network: \$0/day, days 1-20. \$100/day, days 21-100. No prior hospital stay required. 100 days each benefit period. Out: \$0/day, days 1-20. \$100/day, days 21-100.
In-patient Mental Health	In Network: \$295/day, days 1-5. \$0/day, days 6-90 and beyond. 190-days psychiatric hospital lifetime limit. Out: \$295/day, days 1-5. \$0/day, days 6-90 and beyond.	In Network: \$295/day, days 1-5. \$0/day, days 6-90 and beyond. 190-days psychiatric hospital lifetime limit. Out: \$295/day, days 1-5. \$0/day, days 6-90 and beyond.	In Network: \$195/day, days 1-5. \$0/day, days 6-90. 190-days psychiatric hospital lifetime limit. Out: \$195/day, days 1-5. \$0/day, days 6-90.	In Network: \$195/day, days 1-5. \$0/day, days 6-90. 190-days psychiatric hospital lifetime limit. Out: \$195/day, days 1-5. \$0/day, days 6-90.
Outpatient Mental Health	50% each session	50% each session	50% each session	50% each session
Outpatient Services/Surgery	\$100 or \$200 each visit depending on facility.	\$100 or \$200 each visit depending on facility.	\$75 or \$100 each visit depending on facility.	\$75 or \$100 each visit depending on facility.
Ambulance	\$150 each service	\$150 each service	\$100 each service	\$100 each service
Emergency Room Visit	\$50 each visit, waived if admitted.	\$50 each visit, waived if admitted.	\$50 each visit, waived if admitted.	\$50 each visit. If admitted to hospital, copay waived.
Outpatient Rehabilitation Services	\$35 each visit	\$35 each visit	\$15 each visit	\$15 each visit
Durable Medical Equipment	In Network: 20% of the cost of each Medicare-covered item. Out: 0-20% of the cost.	In Network: 20% of the cost of each Medicare-covered item. Out: 0-20% of the cost.	In Network: 20% of the cost of each Medicare-covered item. Out: 0-20% of the cost.	In Network: 20% of the cost of each Medicare-covered item. Out: 0-20% of the cost.
Diagnostic Tests, X-Rays, and Lab Services	In Network: 0% for lab services and diagnostic services. 20% for X-rays, diagnostic and therapeutic radiology. Out: 0-20% for diagnostic procedures, tests, lab services, therapeutic radiology, X-rays, and diagnostic radiology.	In Network: 0% for lab services and diagnostic services. 20% for X-rays, diagnostic and therapeutic radiology. Out: 0-20% for diagnostic procedures, tests, lab services, therapeutic radiology, X-rays, and diagnostic radiology.	In Network: 0% for lab services and diagnostic services. 10% for X-rays, diagnostic and therapeutic radiology. Out: 0-10% for diagnostic procedures, tests, lab services, therapeutic radiology, X-rays, and diagnostic radiology.	In Network: 0% for lab services and diagnostic services. 10% for X-rays, diagnostic and therapeutic radiology. Out: 0-10% for diagnostic procedures, tests, lab services, therapeutic radiology, X-rays, and diagnostic radiology.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	Preventative services not covered. \$0 copay for Medicare-covered service.	Preventative services not covered. \$0 copay for Medicare-covered service.	Preventative services not covered. \$0 copay for Medicare-covered service.	Preventative services not covered. \$0 copay for Medicare-covered service.
Hearing Services	In Network: You pay 100% of the cost of hearing aids. \$35 copay for diagnostic exam. \$35 copay for up to 1 routine test per year. Out: \$35 copay for hearing exams.	In Network: You pay 100% of the cost of hearing aids. \$35 copay for diagnostic exam. \$35 copay for up to 1 routine test per year. Out: \$35 copay for hearing exams.	In Network: You pay 100% of the cost of hearing aids. \$15 copay for diagnostic exam. \$15 copay for up to 1 routine test per year. Out: \$15 copay for hearing exams.	In Network: You pay 100% of the cost of hearing aids. \$15 copay for diagnostic exam. \$15 copay for up to 1 routine test per year. Out: \$15 copay for hearing exams.
Vision Services	In Network: \$35 for eye wear after cataract surgery. \$35 copay for exams to diagnose and treat diseases. \$35 for 1 routine exam per year. Out: \$35 for exams. \$35 for eye wear.	In Network: \$35 for eye wear after cataract surgery. \$35 copay for exams to diagnose and treat diseases. \$35 for 1 routine exam per year. Out: \$35 for exams. \$35 for eye wear.	In Network: \$15 for eye wear after cataract surgery. \$15 copay for exams to diagnose and treat diseases. \$15 for 1 routine exam per year. Out: \$15 for exams. \$15 for eye wear.	In Network: \$15 for eye wear after cataract surgery. \$15 copay for exams to diagnose and treat diseases. \$15 for 1 routine exam per year. Out: \$15 for exams. \$15 for eye wear.
Miscellaneous	Written health/wellness materials and Nursing Hotline	Written health/wellness materials and Nursing Hotline	Written health/wellness materials and Nursing Hotline	Written health/wellness materials, Nursing Hotline
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.

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Medicare Advantage PFFS Plans
Comparison Chart**

Company	WellCare	WellCare	WellCare	WellCare
Plan Name	Concert Plan	Melody Plan	Serenade Plan	Sonata Plan
Telephone Numbers Website	New enrollment: 1-866-238-9898 Current Members: 1-866-238-9898 wellcarepffs.com	New enrollment: 1-866-238-9898 Current Members: 1-866-238-9898 wellcarepffs.com	New enrollment: 1-866-238-9898 Current Members: 1-866-238-9898 wellcarepffs.com	New enrollment: 1-866-238-9898 Current Members: 1-866-238-9898 wellcarepffs.com
Plan Type	PRIVATE FEE FOR SERVICE Includes Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.	PRIVATE FEE FOR SERVICE Plan does NOT have Prescription Drug Benefit. May use any provider that accepts the plan's payment.
Monthly Premium	\$29 Monthly Premium. \$135 yearly deductible. \$3,750 Out-of-pocket limit per year. Contact plan for services that apply.	\$0 Monthly Premium. \$135 yearly deductible.	\$79 Monthly Premium \$3,500 out-of-pocket limit Contact the plan for services that apply	\$0 Monthly Premium. \$135 yearly deductible. (\$4000 out-of-pocket limit on certain Medicare services)
Doctor Visit	\$20-\$35 each visit	20% of the cost each visit	\$15-\$35 each visit	\$20-\$35 each visit
Specialist Visit	\$35 each visit	20% of the cost each visit	\$35 each visit	\$35 each visit
Physician Network	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment	Any provider willing to take plan's payment
In-patient Hospitalization	\$250/day, days 1-5. \$0/day, days 6-90. \$0/day for 60 lifetime reserve days. 90 days each benefit period.	\$1024 yearly deductible. \$0/day, days -60. \$256/day, days 61-90. \$512/day for 60 lifetime reserve days. 90 days each benefit period.	\$125/day, days 1-5. \$0/day, days 6-90. \$0/day for 60 lifetime reserve days. 90 days each benefit period.	\$200/day, days 1-6. \$0/day, days 7-90. \$0/day for 60 lifetime reserve days. 90 days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-20. \$128/day, days 21-100. No prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$128/day, days 21-100. 3 day prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$128/day, days 21-100. No prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$128/day, days 21-100. No prior hospital stay required. 100 days each benefit period.
In-patient Mental Health	\$250/day, days 1-5. \$0/day, days 6-90. \$0/day for 60 lifetime reserve days. 190-days psychiatric hospital lifetime limit.	\$1024 yearly deductible. \$0/day, days 1-60. \$256/day, days 61-90. \$512/day for 60 lifetime reserve days. 190-days psychiatric hospital lifetime limit.	\$125/day, days 1-5. \$0/day, days 6-90. \$0/day for 60 lifetime reserve days. 190-days psychiatric hospital lifetime limit.	\$200/day, days 1-6. \$0/day, days 7-90. \$0/day for 60 lifetime reserve days. 190-days psychiatric hospital lifetime limit.
Outpatient Mental Health	\$35 each individual session \$25 each group session	20% for 1st session, 50% for subsequent sessions.	\$35 per private session \$25 per group session	\$35 per private session \$25 per group session
Outpatient Services/Surgery	\$75 or \$150 depending on the facility	20% each visit	\$55 or \$105 depending on the facility.	\$75 or \$150 depending on the facility.
Ambulance	\$100 each service	20% each service	\$100 each service	\$100 each service
Emergency Room Visit	\$50 each visit, waived if admitted.	20% of the cost up to \$50 each visit, waived if admitted	\$50 each visit, waived if admitted	\$50 each visit, waived if admitted
Outpatient Rehabilitation Services	\$35 each visit or 20% of the cost	20% of the cost each visit	\$35 each visit or 20% of the cost	\$35 each visit or 20% of the cost
Durable Medical Equipment	20% of the cost for Medicare-covered items.	20% of the cost for Medicare-covered items.	20% of the cost for Medicare-covered items.	20% of the cost for Medicare-covered items.
Diagnostic Tests, X-Rays, and Lab Services	\$0-\$20 each lab service. \$0-\$20 or 20% for diagnostic services. \$0-\$20 for X-rays. 20% for diagnostic or therapeutic radiology.	\$0 each lab service. 20% of the cost for diagnostic services. 20% of the cost for X-rays. 20% of the cost for diagnostic and therapeutic radiology.	\$0-\$20 each lab service. \$0-\$20 or 20% of the cost for diagnostic services. \$0-\$20 for X-rays. 20% of the cost for diagnostic and therapeutic radiology.	\$0-\$20 each lab service. \$0-\$20 or 20% of the cost for diagnostic services. \$0-\$20 for X-rays. 20% of the cost for diagnostic and therapeutic radiology.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	20% for Medicare-covered benefits. \$20 copay for up to 1 exam every 6 months. \$20 copay for up to 1 cleaning every 6 months. \$20-\$30 copay for 1 X-ray.	20% for Medicare-covered benefits. \$0 copays for up to 1 oral exam, 1 cleaning and 1 fluoride treatment every 6 months. \$0 copay for up to 1 X-ray. \$1000 limit for dental benefits each yr.	20% for Medicare-covered benefits. \$0 copays for up to 1 oral exam, 1 cleaning and 1 fluoride treatment every 6 months. \$0 copay for up to 1 X-ray. \$1000 limit for dental benefits each yr.	20% for Medicare-covered benefits. \$20 copays for up to 1 oral exam and 1 cleaning every 6 months. \$20-\$30 copay for up to 1 X-ray.
Hearing Services	20% for diagnostic exams. \$0 for 1 routine test per yr. \$0 for up to 2 hearing aid fitting evals every 3 yrs. \$0 for up to 2 hearing aids every 3 yrs. \$1000 limit for hearing aids every 3 yrs.	20% for diagnostic exams. \$0 for up to 1 routine test per yr. \$0 for up to 2 hearing aid fitting evals every 3 yrs. \$0 for up to 2 hearing aids every 3 yrs. \$50 limit for routine tests every yr. \$1000 limit every 3 yrs for hearing aids.	20% for diagnostic exams. \$0 for up to 1 routine test per yr. \$0 for up to 2 hearing aid fitting evals every 3 yrs. \$0 for up to 2 hearing aids every 3 yrs. \$50 limit for routine tests every yr. \$1000 limit every 3 yrs for hearing aids.	20% for diagnostic exams. \$0 for up to 1 routine test per yr. \$0 for up to 2 hearing aid fitting evals every 3 yrs. \$0 for up to 2 hearing aids every 3 yrs. \$50 limit for routine tests every yr. \$500 limit every 3 yrs for hearing aids.
Vision Services	20% of the cost for 1 pair of glasses or contacts after cataract surgery. 20% of the cost for exams to diagnose and treat conditions. \$0 for 1 routine exam per yr. \$10 copays for glasses, contacts, lenses and frames. \$50 limit for exams per yr. \$100 limit for eye wear.	20% of the cost for one pair or glasses or contacts after cataract surgery. 20% of the cost for exams to diagnose and treat conditions. \$0 for up to 1 routine exam per yr. \$10 copays for 1pair of glasses, 1 set of contacts, 1 pair of lenses, and 1 set of frames. \$50 limit for exams. \$260 limit for eye wear per yr.	20% of the cost for one pair or glasses or contacts after cataract surgery. 20% of the cost for exams to diagnose and treat conditions. \$0 for up to 1 routine exam per yr. \$10 copays for 1pair of glasses, 1 set of contacts, 1 pair of lenses, and 1 set of frames. \$50 limit for exams. \$260 limit for eye wear per yr.	20% of the cost for one pair or glasses or contacts after cataract surgery. 20% of the cost for exams to diagnose and treat conditions. \$0 for up to 1 routine exam per yr. \$50 limit for exams.
Miscellaneous	Written health/wellness materials, Nursine Hotline	Written health/wellness materials, Nursine Hotline	Written health/wellness materials, Nursine Hotline, Health Club Membership	Written health/wellness materials, Nursine Hotline
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.	No Prescription Drug benefit with this plan.	No Prescription Drug benefit with this plan.