



Group Plan Coverage – T300 Deductible Benefit Plan Series

SUMMARY OF BENEFITS AND COVERAGE	T321X	T322X	T323X	T324X	T325X
PLAN YEAR DEDUCTIBLE	\$500 Individual Contract/\$1,300 Family Contract				
OUT OF POCKET MAXIMUMS (includes Deductibles and Coinsurance)	\$1,500 Individual Contract/\$3,900 Family Contract* (*Only applies to Options 324X and 325X)				
PHYSICIAN SERVICES / PREVENTATIVE SERVICES	Member only pays one Co-pay per office visit				
Primary care office visits	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Specialist office visits	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Annual physical exam	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Annual well woman visit	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Hearing and vision screening	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Immunizations (pediatric)	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
PSA screening	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Well child care	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Allergy test, treatments, and injections	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Chiropractic care (20 visits per year)	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Nutritional counseling and education	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
Health education and counseling	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay	\$20 Co-pay
MATERNITY SERVICES					
Prenatal & postnatal care	\$5 Co-pay (one time co-pay)	\$10 Co-pay (one time co-pay)	\$15 Co-pay (one time co-pay)	\$20 Co-pay (one time co-pay)	\$20 Co-pay (one time co-pay)
Delivery in hospital	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible & \$250 Coinsurance Per Admission	Subject to Deductible & \$500 Coinsurance Per Admission
Well baby care in hospital	Covered	Covered	Covered	Covered	Covered
INPATIENT HOSPITAL SERVICES					
Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible & \$250 Coinsurance Per Admission	Subject to Deductible & \$500 Coinsurance Per Admission
OUTPATIENT PROCEDURES					
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drug therapy; lab tests and xrays	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible & \$100 Coinsurance Per Admission	Subject to Deductible & \$250 Coinsurance Per Admission
EMERGENCY MEDICAL SERVICES					
Physician and hospital emergency room services (Co-pay waived if admitted)	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay	\$40 Co-pay
Ambulance services (when medically necessary)	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay	\$75 Co-pay
AFTER HOURS MEDICAL SERVICES					
Participating after-hours care centers (Urgent Care)	Covered	Covered	Covered	Covered	Covered
DIAGNOSTIC & THERAPEUTIC SERVICES					
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Chemotherapy	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Physical, occupational and speech therapy	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Mammograms	Covered	Covered	Covered	Covered	Covered
MENTAL HEALTH CARE					
Outpatient treatment (limited to 20 visits/year)	Covered	Covered	Covered	Covered	Covered
SUBSTANCE ABUSE TREATMENT					
Outpatient Care (limited to state mandated levels)	Covered	Covered	Covered	Covered	Covered
Intermediate Care (limited to state mandated levels)	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible & \$100 Coinsurance Per Episode of Inter. Care	Subject to Deductible & \$250 Coinsurance Per Episode of Inter. Care
OTHER SERVICES					
Home Health Care (limited to 100 visits/year)	Covered	Covered	Covered	Covered	Covered
Hospice care	Covered	Covered	Covered	Covered	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES					
Covered when medically necessary	Covered	Covered	Covered	Covered	Covered
PRESCRIPTION DRUG SERVICES					
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy	\$5/generic \$15/brand*	\$5/generic \$15/brand*	\$10/generic \$20/brand*	\$10/generic \$20/brand*	50%
*When no Generic equivalent is available					

The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.