

PHYSICIAN PREFERRED NETWORK DEDUCTIBLE PLAN SUMMARY OF BENEFITS AND COVERAGE



	Physician Preferred Network	Total Health Care USA
CALENDAR YEAR DEDUCTIBLE		
Per Individual Contract	\$250	Per Individual Contract \$500
Per Family Contract	\$650	Per Family Contract \$1,300
PHYSICIAN SERVICES / PREVENTATIVE SERVICES	Member only pays one Co-pay per office visit	
Primary care office visits	\$0 Co-pay	\$10 Co-pay
Specialist office visits	\$0 Co-pay	\$10 Co-pay
Annual physical exam	\$0 Co-pay	\$10 Co-pay
Annual well woman visit	\$0 Co-pay	\$10 Co-pay
Immunizations (pediatric)	\$0 Co-pay	\$10 Co-pay
Well child care	\$0 Co-pay	\$10 Co-pay
Allergy test, treatments, and injections	\$0 Co-pay	\$10 Co-pay
Chiropractic care (20 visits/year)	\$0 Co-pay	\$10 Co-pay
Nutritional counseling and education	\$0 Co-pay	\$10 Co-pay
Health education and counseling	\$0 Co-pay	\$10 Co-pay
MATERNITY SERVICES		
Prenatal & postnatal care	\$0 Co-pay	\$10 Co-pay (one time Co-pay)
Delivery in hospital	Deductible	Deductible
Well baby care in hospital	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	Deductible	Deductible
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	Deductible	Deductible
EMERGENCY MEDICAL SERVICES		
Physician and hospital emergency room services (Co-pay waived if admitted)	\$100 Co-pay	\$100 Co-pay
Ambulance services	\$75 Co-pay	\$75 Co-pay
AFTER HOURS MEDICAL SERVICES		
Participating after-hours care centers (Urgent Care)	\$25 Co-pay	\$25 Co-pay
DIAGNOSTIC & THERAPEUTIC SERVICES		
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Deductible	Deductible
Chemotherapy	Deductible	Deductible
Physical, occupational and speech therapy (limited to 45 days per/year)	\$0 Co-pay	\$10 Co-pay
Non-preventative diagnostics including lab, x-ray, and special diagnostics in a non-hospital setting	\$0 Co-pay	\$10 Co-pay
Mammograms	Covered	Covered
MENTAL HEALTH CARE		
Outpatient treatment (limited to 20 visits/year)	Covered	Covered
Inpatient psychiatric hospital services (limited to 45 days/renewable benefit)	Deductible	Deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient Care (limited to state mandated levels)	Covered	Covered
Intermediate Care (limited to state mandated levels)	Deductible	Deductible
OTHER SERVICES		
Home Health Care (limited to 100 visits/year)	Covered	Covered
Hospice care	Covered	Covered
SKILLED NURSING CARE FACILITY	Subject to Total Health Care USA rider	
Limited to 120 days/year	Covered	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES		
Covered when medically necessary	Covered	Covered
HEARING SERVICES	Subject to Total Health Care USA rider	
Hearing exam and hearing aid testing	Covered	Covered
Hearing aid (limited to one every three years)	Covered	Covered
VISION SERVICES	Subject to Total Health Care USA rider	
Eye exam (limited to one/year)	Covered	Covered
Eyeglasses (limited to one pair every two years)	Covered	Covered
PRESCRIPTION DRUG SERVICES	Subject to Total Health Care USA rider	
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy *When <u>no</u> Generic equivalent is available	Refer to Pharmacy Rider	

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