# PHYSICIAN PREFERRED NETWORK DEDUCTIBLE PLAN SUMMARY OF BENEFITS AND COVERAGE

Powered by

| | Physician Preferred Network | Total Health Care USA | Cofinity (PPOM) Network | Out-of-Network |
|---|---|---|---|---|
| CALENDAR YEAR DEDUCTIBLE | | | | |
| | Per Individual Contract $300 | | Per Individual Contract $600 | Per Individual Contract $900 |
| | Per Family Contract $600 | | Per Family Contract $1,200 | Per Family Contract $1,800 |
| OUT OF POCKET MAXIMUM (includes Deductibles and Coinsurance) | | | | |
| | Per Individual Contract $300 | | Per Individual Contract $2,000 | Per Individual Contract $7,500 |
| | Per Family Contract $600 | | Per Family Contract $4,000 | Per Family Contract $15,000 |
| PERCENTAGE COINSURANCE PAID BY MEMBER | | | | |
| | 0% | 0% | 20% of Cofinity (PPOM) Rate | 40% of Charges |
| PHYSICIAN SERVICES / PREVENTATIVE SERVICES | Member only pays one Co-pay per office visit | | | |
| Primary care office visits | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Specialist office visits | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Annual physical exam | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Annual well woman visit | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Immunizations (pediatric) | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Well child care | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Allergy test, treatments, and injections | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Chiropractic care (20 visits/year) | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Nutritional counseling and education | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Health education and counseling | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| MATERNITY SERVICES | | | | |
| Prenatal & postnatal care | $2 Co-pay (one time Co-pay) | $25 Co-pay (one time Co-pay) | $40 Co-pay (one time Co-pay) | Deductible and Coinsurance |
| Delivery in hospital | Subject to Deductible | | Deductible and Coinsurance | Deductible and Coinsurance |
| Well baby care in hospital | Covered | | Coinsurance | Coinsurance |
| 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 | | Deductible and Coinsurance | Deductible and Coinsurance |
| 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 | | Deductible and Coinsurance | Deductible and Coinsurance |
| EMERGENCY MEDICAL SERVICES | | | | |
| Physician and hospital emergency room services (Co-pay waived if admitted) | $125 Co-pay | $125 Co-pay | $125 Co-pay | $125 Co-pay |
| Ambulance services (when medically necessary) | $75 Co-pay | $75 Co-pay | $75 Co-pay | $75 Co-pay |
| AFTER HOURS MEDICAL SERVICES | | | | |
| Participating after-hours care centers (Urgent Care) | $25 Co-pay | $25 Co-pay | $50 Co-pay | Deductible and Co-pay |
| DIAGNOSTIC & THERAPEUTIC SERVICES | | | | |
| Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital | Deductible | | Deductible and Coinsurance | Deductible and Coinsurance |
| Chemotherapy | Deductible | | Deductible and Coinsurance | Deductible and Coinsurance |
| Physical, occupational and speech therapy (limited to 45 days/year) | $2 Co-pay | $25 Co-pay | $40 Co-pay | Deductible and Co-pay |
| Non-preventative diagnostics including lab, x-ray, and special diagnostics in a non-hospital setting | Deductible | | Deductible and Coinsurance | Deductible and Coinsurance |
| Mammograms | Covered | | $40 Co-pay | Deductible and Co-pay |
| MENTAL HEALTH CARE | | | | |
| Outpatient treatment (limited to 20 visits/year) | Covered | | $40 Co-pay | Not Covered |
| Inpatient psychiatric hospital services (limited to 45 days/renewable benefit) | Deductible | | Deductible and Coinsurance | Not Covered |
| SUBSTANCE ABUSE TREATMENT | | | | |
| Outpatient Care (limited to state mandated levels) | Covered | | $40 Co-pay | Not Covered |
| Intermediate Care (limited to state mandated levels) | Deductible | | Deductible and Coinsurance | Not Covered |
| OTHER SERVICES | | | | |
| Home Health Care (limited to 100 visits/year) | Covered | | Not Covered | Not Covered |
| Hospice care | Covered | | Deductible and Coinsurance | Deductible and Coinsurance |
| SKILLED NURSING CARE FACILITY | Subject to Total Health Care USA rider | | | |
| Limited to 120 days/year | Covered | | Not Covered | Not Covered |
| DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES | Subject to Total Health Care USA rider | | | |
| Covered when medically necessary | Covered | | Not Covered | Not Covered |
| HEARING SERVICES | Subject to Total Health Care USA rider | | | |
| Hearing exam and hearing aid testing | Covered | | Not Covered | Not Covered |
| Hearing aid (limited to one every three years) | Covered | | Not Covered | Not Covered |
| VISION SERVICES | Subject to Total Health Care USA rider | | | |
| Eye exam (limited to one/year) | Covered | | Not Covered | Not Covered |
| Eyeglasses (limited to one pair every two years) | Covered | | Not Covered | Not 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 no 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.