



## Group Plan Coverage – 521 Benefit Plan Series

SUMMARY OF BENEFITS AND COVERAGE	Option A	Option B	Option C	Option D	Option E
<b>PHYSICIAN SERVICES / PREVENTATIVE SERVICES</b>	<b>Member only pays one Co-pay per office visit</b>				
Primary care office visits	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Specialist office visits	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Annual physical exam	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Annual well woman visit	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Hearing and vision screening	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Immunizations (pediatric)	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
PSA screening	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Well child care	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Allergy test, treatments, and injections	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Chiropractic care (20 visits per year)	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Nutritional counseling and education	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
Health education and counseling	\$5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$15 Co-pay	\$20 Co-pay
<b>MATERNITY SERVICES</b>					
Prenatal & postnatal care	\$5 Co-pay (one time co-pay)	\$10 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)
Delivery in hospital	Covered	Covered	Covered	\$250 Coinsurance	\$500 Coinsurance
Well baby care in hospital	Covered	Covered	Covered	Covered	Covered
<b>INPATIENT HOSPITAL SERVICES</b>					
Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays	Covered	Covered	Covered	\$250 Coinsurance Per Admission	\$500 Coinsurance Per Admission
<b>OUTPATIENT PROCEDURES</b>					
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drug therapy; lab tests and xrays	Covered	Covered	Covered	\$100 Coinsurance Per Procedure	\$250 Coinsurance Per Procedure
<b>EMERGENCY MEDICAL SERVICES</b>					
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
<b>AFTER HOURS MEDICAL SERVICES</b>					
Participating after-hours care centers (Urgent Care)	Covered	Covered	Covered	Covered	Covered
<b>DIAGNOSTIC &amp; THERAPEUTIC SERVICES</b>					
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Covered	Covered	Covered	Covered	Covered
Chemotherapy	Covered	Covered	Covered	Covered	Covered
Physical, occupational and speech therapy	Covered	Covered	Covered	Covered	Covered
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Covered	Covered	Covered	Covered	Covered
Mammograms	Covered	Covered	Covered	Covered	Covered
<b>MENTAL HEALTH CARE</b>					
Outpatient treatment (limited to 20 visits/year)	Covered	Covered	Covered	Covered	Covered
Inpatient psychiatric hospital services (limited to 45 days per calendar year)	Covered	Covered	Covered	Covered	Covered
<b>SUBSTANCE ABUSE TREATMENT</b>					
Outpatient Care (limited to state mandated levels)	Covered	Covered	Covered	Covered	Covered
Intermediate Care (limited to state mandated levels)	Covered	Covered	Covered	Covered	Covered
<b>OTHER SERVICES</b>					
Home Health Care (limited to 100 visits/year)	Covered	Covered	Covered	Covered	Covered
Hospice care	Covered	Covered	Covered	Covered	Covered
Skilled Nursing Care Facility (limited to 120 days per calendar year)	Covered	Covered	Covered	Covered	Covered
<b>DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES</b>					
Covered when medically necessary	Covered	Covered	Covered	Covered	Covered
<b>HEARING SERVICES</b>					
Hearing exam and hearing aid testing	Covered	Covered	Covered	Covered	Covered
Hearing aid (limited to one every three years)	Covered	Covered	Covered	Covered	Covered
<b>VISION SERVICES</b>					
Eye exam (limited to one year)	Covered	Covered	Covered	Covered	Covered
Eyeglasses (limited to one pair every two years)	Covered	Covered	Covered	Covered	Covered
<b>PRESCRIPTION DRUG SERVICES</b>					
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy	\$0/generic \$10/brand*	\$0/generic \$10/brand*	\$5/generic \$15/brand*	\$5/generic \$15/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.