



TOTALLY THERE FOR YOU

T300 DEDUCTIBLE BENEFIT PLAN SERIES - GRANDFATHERED

| SUMMARY OF BENEFITS AND COVERAGE | T321X | T322X | T323X | T324X | T325X |
|---|--|----------------------------------|----------------------------------|--|--|
| CALENDAR 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* | | | | |
| PHYSICIAN SERVICES / PREVENTIVE 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 |
| Allergy 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 |
| 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 |
| Well child care | \$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 |
| PSA screening | \$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 drugtherapy; lab tests and x-rays | 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 |
| BEHAVIORAL HEALTH CARE | | | | | |
| Outpatient treatment | Covered | Covered | Covered | Covered | Covered |
| SUBSTANCE ABUSE TREATMENT | | | | | |
| Outpatient Care | Covered | Covered | Covered | Covered | Covered |
| Intermediate Care | Subject to Deductible | Subject to Deductible | Subject to Deductible | Subject to Deductible & \$100 Coinsurance Per Episode of Intermediate Care | Subject to Deductible & \$250 Coinsurance Per Episode of Intermediate 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 *When NO Generic equivalent is available | \$5/Generic \$15/Brand Name* | \$5/Generic \$15/Brand Name* | \$10/Generic \$20/Brand Name* | \$10/Generic \$20/Brand Name* | 50% |

*Only applies to Options 324X and 325X. The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.

T300_DEDUCT_GF_ 8/11