TOTALLY THERE FOR YOU

# T500 BENEFIT PLAN SERIES - GRANDFATHERED

| SUMMARY OF BENEFITS AND COVERAGE | T521 | T522 | T523 | T524 | T525 |
|---|---|---|---|---|---|
| **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 | Covered | Covered | Covered | $250 Coinsurance | $500 Coinsurance |
| 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 | Covered | Covered | Covered | $250 Coinsurance Per Admission | $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 | Covered | Covered | Covered | $100 Coinsurance Per Procedure | $250 Coinsurance Per Procedure |
| **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 | 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 |
| **BEHAVIORAL HEALTH CARE** | | | | | |
| Outpatient treatment | Covered | Covered | Covered | Covered | Covered |
| Inpatient psychiatric hospital services | Covered | Covered | Covered | Covered | Covered |
| **SUBSTANCE ABUSE TREATMENT** | | | | | |
| Outpatient Care | Covered | Covered | Covered | Covered | Covered |
| Intermediate Care | Covered | Covered | Covered | Covered | Covered |
| **OTHER SERVICES** | | | | | |
| 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 |
| **DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES** | | | | | |
| Covered when medically necessary | Covered | Covered | Covered | Covered | Covered |
| **HEARING SERVICES** | | | | | |
| Hearing exam and hearing aid testing | Covered | Covered | Covered | Covered | Covered |
| Hearing aid (limited to one every three years) | Covered | Covered | Covered | Covered | Covered |
| **VISION SERVICES** | | | | | |
| Eye exam (limited to one year) | Covered | Covered | Covered | Covered | Covered |
| Eyeglasses (limited to one pair every two years) | Covered | Covered | Covered | Covered | Covered |
| **PRESCRIPTION DRUG SERVICES** | | | | | |
| Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy<br>*When NO Generic equivalent is available | $5/Generic<br>$15/Brand Name* | $5/Generic<br>$15/Brand Name* | $10/Generic<br>$20/Brand Name* | $10/Generic<br>$20/Brand Name* | 50% |

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