



T500 DEDUCTIBLE BENEFIT PLAN SERIES - GRANDFATHERED

SUMMARY OF BENEFITS AND COVERAGE	T521X	T522X	T523X	T524X	T525X
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 drug therapy; 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
Inpatient psychiatric hospital services	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible & \$250 Coinsurance Per Admission	Subject to Deductible & \$500 Coinsurance Per Admission
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
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 *When <u>NO</u> 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 524X and 525X. The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.