



TOTALLY THERE FOR YOU



PPN / SELECT - GRANDFATHERED

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%		20% of Cofinity (PPOM) Rate		40% of Charges

PHYSICIAN SERVICES / PREVENTIVE SERVICES

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
Allergy injections	\$2 Co-pay	\$25 Co-pay	\$40 Co-pay	Deductible and Co-pay
Chiropractic care (20 visits per year)	\$2 Co-pay	\$25 Co-pay	\$40 Co-pay	Deductible and Co-pay
Hearing and vision screening	\$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
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
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
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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		Deductible and Coinsurance	Deductible and Coinsurance
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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 Co-pay
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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 per year)	\$2 Co-pay	\$25 Co-pay	\$40 Co-pay	Deductible Co-pay
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Deductible		Deductible and Coinsurance	Deductible and Coinsurance
Mammograms	Covered		\$40 Co-pay	Deductible Co-pay

BEHAVIORAL HEALTH CARE

Outpatient treatment	Covered		\$40 Co-pay	Subject to Deductible and Coinsurance
Inpatient psychiatric hospital services	Deductible		Deductible and Coinsurance	Subject to Deductible and Coinsurance

SUBSTANCE ABUSE TREATMENT

Outpatient Care	Covered		\$40 Co-pay	Subject to Deductible and Coinsurance
Intermediate Care	Deductible		Deductible and Coinsurance	Subject to Deductible and Coinsurance

OTHER SERVICES

Home Health Care (limited to 100 visits/year)	Covered		Not Covered	Not Covered
Hospice Care	Covered		Subject to Deductible and Coinsurance	Deductible and Coinsurance

SKILLED NURSING CARE FACILITY

limited to 120 days per year	Covered		Not Covered	Not Covered
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DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES

Covered when medically necessary	Covered		Not Covered	Not Covered
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HEARING SERVICES

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

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

Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy			\$10/Generic	\$20/Brand Name*
*When NO Generic equivalent is available				