



Benefit Information	TOTAL HMO 2B3000B
	THC Network
<b>Medical</b>	
Deductible	\$3,000 Annual per Member \$6,000 Annual per Family
Co-Insurance	0%
OOP Maximum	\$3,500 per Member \$7,000 per Family
<b>Pharmacy</b>	
Annual Deductible	\$0 per Member
Co-Insurance	0%
OOP Maximum	\$2,850 per Member \$5,700 per Family
<b>Combined OOP Maximum</b>	\$6,350 per Individual \$12,700 per Family
<b>Physician/Preventative Services</b>	
Primary Care Visit	\$20 Copay
Specialty Care	\$40 Copay
Prenatal and Postnatal Care (One time copay)	\$40 Copay
Well Baby Visits	100% Covered
Allergy Injections	\$40 Copay
Allergy Testing	\$40 Copay
Chiropractic Care (20 visits per calendar year)	\$40 Copay
PT/OT/ST (45 combined visits per calendar year)	\$40 Copay
Diabetes Education	100% Covered
Dietitian Services (Nutritional Counseling)	100% Covered
Mammograms	100% Covered
Preventative Care/Screening/Immunizations	100% Covered
Weight Loss Programs	100% Covered
<b>Inpatient Services</b>	
Inpatient Stay	Subject to deductible
Inpatient Physician & Surgical Services	Subject to deductible
Delivery and all inpatient services for Maternity Care	Subject to deductible
Reconstructive Surgery	Subject to deductible
Transplant	Subject to deductible
<b>Outpatient Services</b>	
Outpatient Surgery Physician/Surgical Services	Subject to deductible
Outpatient Facility Fee	Subject to deductible
Outpatient Rehabilitation Services	\$40 Copay
Chemotherapy	100% Covered
Dialysis	100% Covered
Imaging (CT/PET Scans, MRIs)	100% Covered
Infusion Therapy	100% Covered
Laboratory Outpatient & Professional Services	100% Covered
Radiation Therapy	100% Covered
Temporomandibular Joint Disorders	50% Coverage
X-Rays & Diagnostic Imaging	100% Covered
<b>Emergency/After Hours Medical Services</b>	
Emergency Room	\$150 Copay
Urgent Care	\$40 Copay
Ambulance Services (When Medically Necessary)	\$75 Copay
<b>Mental Health/Substance Abuse Services</b>	



Mental / Behavioral Health Outpatient Services	\$40 Copay
Mental / Behavioral Health Inpatient Services	Subject to deductible
Substance Abuse Outpatient	\$40 Copay
Substance Abuse Intermediate	\$100 Copay
Substance Abuse Inpatient	Subject to deductible
<b>Other Services</b>	
Home Health Care (limited to 100 days per calendar year)	100% Covered
Skilled Nursing Facility (limited to 45 days per calendar year)	Subject to deductible
Hospice Services	100% Covered
<b>Durable Medical Equipment / Prosthetic Devices</b>	
DME	100% Covered
Prosthetic Devices	100% Covered
<b>Hearing Services</b>	
Hearing Exam	100% Covered
Hearing Aids	Plan pays a max \$600 per ear every 3 years
<b>Vision Services</b>	
Routine Eye Exam (Adult & Pediatric)	100% Coverage - one visit per calendar year
Eye Glasses for Adults	100% Coverage on selected lenses and frames
Eye Glasses for Children	100% Coverage on selected lenses and frames
<b>Pharmacy</b>	
Generic Copay	\$20 Copay
Preferred Brand	\$40 Copay

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Benefit Information	TOTAL SELECT (POS) MID	
	THC Network	Cofinity Network
<b>Medical</b>		
Deductible	\$500 Annual per Member \$1,000 Annual per Family	\$1,500 Annual per Member \$3,000 Annual per Family
Co-Insurance	0%	25%
OOP Maximum	\$2,500 per Member \$5,000 per Family	\$2,500 per Member \$5,000 per Family
<b>Pharmacy</b>		
Annual Deductible	\$0 per Member	
Co-Insurance	0%	
OOP Maximum	\$3,850 per Individual \$7,700 per Family	
<b>Combined OOP Maximum</b>	\$6,350 per Individual \$12,700 per Family	
<b>Physician/Preventative Services</b>		
Primary Care Visit	\$15 Copay	\$40 Copay
Specialty Care	\$30 Copay	\$50 Copay
Prenatal and Postnatal Care (One time copay)	\$30 Copay	\$50 Copay
Well Baby Visits	100% Covered	\$40 Copay
Allergy Injections	\$30 Copay	\$50 Copay
Allergy Testing	\$30 Copay	\$50 Copay
Chiropractic Care (20 visits per calendar year)	\$30 Copay	\$50 Copay
PT/OT/ST (45 combined visits per calendar year)	\$30 Copay	\$50 Copay
Diabetes Education	100% Covered	Covered in THC Network only
Dietitian Services (Nutritional Counseling)	100% Covered	Covered in THC Network only
Mammograms	100% Covered	\$50 Copay
Preventative Care/Screening/Immunizations	100% Covered	\$40 Copay
Weight Loss Programs	100% Covered	Covered in THC Network only
<b>Inpatient Services</b>		
Inpatient Stay	Subject to deductible	25% Coinsurance after deductible
Inpatient Physician & Surgical Services	Subject to deductible	25% Coinsurance after deductible
Delivery and all inpatient services for Maternity Care	Subject to deductible	25% Coinsurance after deductible
Reconstructive Surgery	Subject to deductible	25% Coinsurance after deductible
Transplant	Subject to deductible	Covered in THC Network only
<b>Outpatient Services</b>		
Outpatient Surgery Physician/Surgical Services	Subject to deductible	25% Coinsurance after deductible
Outpatient Facility Fee	Subject to deductible	25% Coinsurance after deductible
Outpatient Rehabilitation Services	\$30 Copay	\$50 Copay
Chemotherapy	Subject to deductible	25% Coinsurance after deductible
Dialysis	Subject to deductible	25% Coinsurance after deductible
Imaging (CT/PET Scans, MRIs)	Subject to deductible	25% Coinsurance after deductible
Infusion Therapy	Subject to deductible	25% Coinsurance after deductible
Laboratory Outpatient & Professional Services	Subject to deductible	25% Coinsurance after deductible
Radiation Therapy	Subject to deductible	25% Coinsurance after deductible
Temporomandibular Joint Disorders	50% Coverage	50% Coverage
X-Rays & Diagnostic Imaging	Subject to deductible	25% Coinsurance after deductible



<b>Emergency/After Hours Medical Services</b>		
Emergency Room	\$125 Copay	\$125 Copay
Urgent Care	\$30 Copay	\$60 Copay
Ambulance Services (When Medically Necessary)	\$75 Copay	\$75 Copay
<b>Mental Health/Substance Abuse Services</b>		
Mental / Behavioral Health Outpatient Services	\$30 Copay	\$50 Copay
Mental / Behavioral Health Inpatient Services	Subject to deductible	25% Coinsurance after deductible
Substance Abuse Outpatient	\$30 Copay	\$50 Copay
Substance Abuse Intermediate	\$100 Copay and subject to deductible	25% Coinsurance after deductible
Substance Abuse Inpatient	Subject to deductible	25% Coinsurance after deductible
<b>Other Services</b>		
Home Health Care (limited to 100 days per calendar year)	100% Covered	Covered in THC Network only
Skilled Nursing Facility (limited to 45 days per calendar year)	Subject to deductible	Covered in THC Network only
Hospice Services	100% Covered	25% Coinsurance after deductible
<b>Durable Medical Equipment / Prosthetic Devices</b>		
DME	100% Covered	Covered in THC Network only
Prosthetic Devices	100% Covered	Covered in THC Network only
<b>Hearing Services</b>		
Hearing Exam	100% Covered	Covered in THC Network only
Hearing Aids	Plan pays a max \$600 per ear every 3 years	Covered in THC Network only
<b>Vision Services</b>		
Routine Eye Exam (Adult & Pediatric)	100% Coverage one visit per calendar year	Covered in THC Network only
Eye Glasses for Adults	100% Coverage on selected lenses and frames	Covered in THC Network only
Eye Glasses for Children	100% Coverage on selected lenses and frames	Covered in THC Network only
<b>Pharmacy</b>		
Generic Copay	\$20 Copay	\$20 Copay
Preferred Brand	\$40 Copay	\$40 Copay

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