Benefit Information	TOTAL HMO 2B100A
	THC Network
Medical	
Deductible	$0
Co-Insurance	0%
OOP Maximum	$1,500 per Member $3,000 per Family
Pharmacy	
Annual Deductible	$0 per Member
Co-Insurance	0%
OOP Maximum	$4,850 per Member $9,700 per Family
Combined OOP Maximum	$6,350 per Individual $12,700 per Family
Physician/Preventative Services	
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
Inpatient Services	
Inpatient Stay	$250 Copay
Inpatient Physician & Surgical Services	100% Covered
Delivery and all inpatient services for Maternity Care	$250 Copay
Reconstructive Surgery	$250 Copay
Transplant	$250 Copay
Outpatient Services	
Outpatient Surgery Physician/Surgical Services	100% Covered
Outpatient Facility Fee	$100 Copay
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

Emergency/After Hours Medical Services	
Emergency Room	$100 Copay
Urgent Care	$40 Copay
Ambulance Services (When Medically Necessary)	$75 Copay
Mental Health/Substance Abuse Services	
Mental / Behavioral Health Outpatient Services	$40 Copay
Mental / Behavioral Health Inpatient Services	$250 Copay
Substance Abuse Outpatient	$40 Copay
Substance Abuse Intermediate	$100 Copay
Substance Abuse Inpatient	$250 Copay
Other Services	
Home Health Care (limited to 100 days per calendar year)	100% Covered
Skilled Nursing Facility (limited to 45 days per calendar year)	100% Covered
Hospice Services	100% Covered
Durable Medical Equipment / Prosthetic Devices	
DME	100% Covered
Prosthetic Devices	100% Covered
Hearing Services	
Hearing Exam	100% Covered
Hearing Aids	Plan pays a max $600 per ear every 3 years
Vision Services	
Routine Eye Exam (Adult & Pediatric)	100% Coverage - one visit per calandar year
Eye Glasses for Adults	100% Coverage on selected lenses and frames
Eye Glasses for Children	100% Coverage on selected lenses and frames
Pharmacy	
Generic Copay	$20 Copay
Preferred Brand	$40 Copay

The Benefits described above are intended to be only a Summary Description. For details, please review the Certificate of Coverage Agreement.