HOPEHEALTH
WITH HOPE, ALL THINGS ARE POSSIBLE

Medical Plan Benefits Summary

Benefits	HopeHealth Facilities	BCBSSC PPO In-Network	Out-of-Network
Deductible			
Individual	$1,000	$1,000	$2,000
Family	$3,000	$3,000	$6,000
Note: The amount applied toward the Non-PPO Deductible will not be used in the accumulation towards the satisfaction of the PPO Deductible.			
COINSURANCE MAXIMUM			
Individual	$1,500	$1,500	$2,000
Family	$3,000	$3,000	$6,000
Out of Pocket MAX			
Individual	$7,150	$7,150	$14,300
Family	$14,300	$14,300	$28,600
Note: The Out-of-Pocket Limit includes Deductible, Coinsurance and Copayments.			
Office Visits			
Primary *Including in-office Surgery, Lab, X-ray, Pathology, Radiology, Injections and Supplies*	100%	$20 Co-pay, 100%	60% after Deductible
Specialist *Including in-office Surgery, Lab, X-ray, Pathology, Radiology, Injections and Supplies*	100%	$40 Co-pay, 100%	60% after Deductible
Urgent Care	100%	$20 Co-pay, 100%	60% after Deductible
Routine/Wellness			
Routine Exam, Well Baby/Child, Immunizations, Mammograms (40+ years), Pap Smears, Prostate Screening, Colonoscopy *Limited to once per benefit year*	100%	100%	No Benefits
All Other Preventive Screenings	100%	N/A	No Benefits
Inpatient			
Hospital	N/A	80% after Deductible	60% after Deductible
Outpatient			
Emergency Room	N/A	80% after Deductible and $250 Co-pay	60% after Deductible and $250 Co-pay
Diagnostic/X-ray/Lab	80% after Deductible	80% after Deductible and $150 Co-pay	60% after Deductible and $150 Co-pay

Physical, Occupational & Speech/Hearing Therapy *Limited to a combined maximum of 30 visits per plan year*	N/A	80% after Deductible	60% after Deductible
OTHER SERVICES			
Chiropractic *Maximum Benefit: $1,000 per member per Benefit Period or 20 Visits per member per Benefit Period*	N/A	$40 Co-pay, 100%	60% after Deductible
Medical Massage Therapy *Requires a Letter of Medical Necessity* *Maximum Benefit: $1,000 per member per Benefit Period or 20 Visits per member per Benefit Period*	$20 Co-pay, 100%	80% after Deductible	No Benefits
Diabetic Education *Requires a Letter of Medical Necessity*	$20 Co-pay, 100%	80% after Deductible	No Benefits
PHARMACY	**HOPEHEALTH PHARMACY 31-DAY SUPPLY**	**RETAIL PHARMACY 31-DAY SUPPLY**	**MAIL ORDER PHARMACY 90-DAY SUPPLY**
Generic	$4 Co-pay, 100%	$15 Co-pay, 100%	No Benefits
Preferred	$25 Co-pay, 100%	$50 Co-pay, 100%	No Benefits
Non-preferred	$50 Co-pay, 100%	$70 Co-pay, 100%	No Benefits
Specialty	$300 Co-pay		No Benefits
Mail Order	2.5 times retail rate, specialty pharmacy excluded.		

All appeals, benefits, or customer service should be routed to TCC Benefits Administrator.

Certain restrictions may apply to all benefits. For complete benefits including plan limitations and exclusions please see your benefit plan book or contact TCC Benefits Administrator.

TCC Benefits Administrator℠

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