

TRH PLAN COMPARISON (NEW SALES)

CM-LT09-004 (Rev. 3/2012))

PLAN NAME	TRH COMPLETE CARE	TRH ESSENTIAL BENEFITS			TRH PREMIER			TRH MAJOR MEDICAL	HSA QUALIFIED HDHP*	
		625	1225	2025	515	1015	2515		1500 INDIVIDUAL	3000 FAMILY
DEDUCTIBLE	\$1,500 Deductible per person per calendar year	\$600	\$1,200	\$2,000	\$500	\$1,000	\$2,500	\$5,000 Deductible per person per calendar year	\$1,500	\$3,000
COINSURANCE	80%	80%			80%			80%	80%	
<i>OUT-OF-NETWORK</i>	60%	60%			60%			60%	60%	
OUT-OF-POCKET MAXIMUM										
<i>INDIVIDUAL</i>	\$7,500	\$5,000	\$6,000	\$8,000	\$4,000	\$5,000	\$12,500	\$10,000	\$3,000	
<i>FAMILY</i>	\$15,000	NA			\$10,000	\$12,500	\$31,500	\$20,000	\$6,000	
OFFICE VISIT COPAY does not apply to out-of-network services	\$25	\$25			\$15			No Copay	No Copay	
ROUTINE PHYSICAL EXAM:	YES \$150 annual max 6-month waiting period	YES \$150 annual max 6-month waiting period			NO			NO	NO	
ANNUAL OB/GYN EXAM:	YES	YES			YES			YES	YES	
ROUTINE COLONOSCOPY:	YES (members over 50 one every four years)	YES (members over 50 one every four years)			YES (members over 50 one every four years)			YES (members over 50 one every four years)	YES (members over 50 one every four years)	
WELL-CHILD SERVICES:	YES (members under 7 subject to certain guidelines)	Essential Benefits offers individual coverage only			YES (members under 7 subject to certain guidelines)			YES (members under 7 subject to certain guidelines)	YES (members under 7 subject to certain guidelines - family plan only)	
PRESCRIPTION DRUG BENEFITS: <i>prescriptions are subject to deductibles and coinsurance</i>	100% MAC generic-Network 75% MAC non-generic-Network 60% MAC out-of-network \$7,500 max per person	80% network eligible prescriptions 60% out-of-network eligible prescriptions \$12,000 max per person			80% network eligible prescriptions 60% out-of-network eligible prescriptions			80% network eligible prescriptions 60% out-of-network eligible prescriptions	80% network eligible prescriptions 60% out-of-network eligible prescriptions	
DENTAL BENEFITS:	Six-month waiting period \$25 copay per visit \$500 annual max	NO			NO			NO	NO	
ROUTINE VISION BENEFITS:	Six-month waiting period \$40 max eye exam \$100 max eyeglass/contact lenses	NO			NO			NO	NO	

ALWAYS REVIEW YOUR CONTRACT FOR COMPLETE DETAILS OF BENEFITS AND EXCLUSIONS

*\$2,500 Individual, \$5,000 Family deductibles also available for HDHP