Fort Worth Firefighters Healthcare Trust
BASIC PLAN

Covered Benefit	Tier 1 - SWHR / THR Providers/ Cook Children's	Tier 2 – All Other Providers
Annual Deductible	$750 Single / $1,500 Family	$950 Single / $1,900 Family
Annual Out-of-Pocket (Includes deductibles) (Deductible and Out of Pocket amounts cross-apply)	$5,000 Single / $10,000 Family	$5,000 Single / $10,000 Family
Preventative Care		
Periodic Health Exam: routine exam, well childcare office visit, immunizations, routine lab and x-rays, routine prostate test, routine pap test, routine mammogram, etc.)	No Charge When Meeting Federal Preventive Care Guidelines	No Charge When Meeting Federal Preventive Care Guidelines
Physician Office Visits		
Primary Care Office Visit (includes diagnostic laboratory & x-ray's if done in office)	$20 Copay / Visit	$30 Copay / Visit
Specialty Care Office Visit (includes diagnostic laboratory & x-ray's if done in office)	$35 Copay / Visit	$45 Copay / Visit
Maternity - Prenatal	$20 Copay / Initial Visit Only	$30 Copay/Initial Visit Only
Maternity - Delivery	15% After Deductible	25% After Deductible
Other Services		
Urgent Care Facility	$60 Copay / Visit	$75 Copay / Visit
Chiropractic Care	$55 Copay / Visit 24 Visits per Calendar Year – 1 visit/treatment per day	$55 Copay / Visit 24 Visits per Calendar Year – 1 Visit/Treatment per Day
Emergency Medical Transport	15% After Deductible	15% After Deductible
Durable Medical Equipment	15% After Deductible	25% After Deductible
Home Health Care	15% After Deductible 60 Visits Maximum Per Calendar Year	25% After Deductible 60 Visits Maximum Per Calendar Year
Habilitation Services: Physical Therapy, Occupational Therapy & Speech Therapy	$35 Copay / Visit 60 Visits Maximum Per Calendar Year	$45 Copay / Visit 60 Visits Maximum Per Calendar Year
Hospice	15% After Deductible 360 Days Maximum Per Lifetime	25% After Deductible 360 Days Maximum Per Lifetime
Hospital Facility Services		
Inpatient Surgery	15% After Deductible	25% After Deductible
Room & Board	15% After Deductible	25% After Deductible
Outpatient Surgery	15% After Deductible	25% After Deductible
Laboratory / X-Rays	15% Deductible Waived	25% Deductible Waived
MRI, PET Scan, CT Scan	15% After Deductible	25% After Deductible
Emergency Room Services	$250 Copay / Waived if Admitted	$250 Copay / Waived if Admitted
Miscellaneous Hospital Charges (Inpatient and Outpatient)	15% After Deductible	25% After Deductible
Mental and Nervous / Substance Abuse Care (Inpatient and Outpatient)	$35 Copay / Visit - Outpatient 15% After Deductible - Inpatient	$45 Copay / Visit – Outpatient 25% After Deductible - Inpatient
Prescription Drugs		
Annual Deductible	$50 Single / $100 Family	$50 Single / $100 Family
Generic	Retail: $10.00 Copay / Mail Order: $25.00	Retail: $10.00 Copay / Mail Order: $25.00
Preferred Brand	Retail: $30.00 Copay / Mail Order: $75.00	Retail: $30.00 Copay / Mail Order: $75.00
Non-Preferred Brand	Retail: $50.00 Copay / Mail Order: $125.00	Retail: $50.00 Copay / Mail Order: $125.00
Specialty	15% After Deductible; $200 Maximum	15% After Deductible; $200 Maximum

*This summary is for illustrative purposes only. Your Summary Plan Description will supersede any comparison with this document. Precertification may be required for some services. Please refer to your Summary Plan Description.

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LOCAL 440
FORT WORTH PROFESSIONAL FIREFIGHTERS

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