



**TOTALLY THERE FOR YOU**

## TOTAL BRONZE HMO HDHP \$6,600/30%

| Cost Share for Medical Expenses   | Individual                       | Family                           |
|---|----------------------------------|----------------------------------|
| Annual Deductible   | \$6,600                          | \$13,200                         |
| Coinsurance   | 30%                              | 30%                              |
| <b>Cost Share for Pharmacy Expenses<br/>(Co-pays apply toward Max Out of Pocket; pay Co-pay or 50% of charges, whichever is less)</b> |                                  |                                  |
| Deductible (Integrated with Medical)  | 0%                               | 0%                               |
| Generic Co-pay  | 30% Coinsurance after Deductible | 30% Coinsurance after Deductible |
| Preferred Brand Co-pay  | 30% Coinsurance after Deductible | 30% Coinsurance after Deductible |

### NOTES AND DISCLAIMERS

Your **Certificate of Coverage** provides you with important information about how to properly use your health insurance. It includes information about your health care benefits, including Prior Approval requirements for certain services.

This **Schedule of Out of Pocket Expenses** lists your costs when you receive health care. It also shows you the maximum benefit you will receive for any health care service.

Please read the Certificate and this Schedule to fully understand the benefits you are and are not entitled to receive.

Services are covered when they are:

- **Medically/Clinically Necessary\*** when provided by your Affiliated Physician or provided by a Participating Provider and when you have advance approval by us when we consider approval required (except in a Medical Emergency), or provided by an Out of Network Provider upon referral from your Affiliated Physician and with prior approval.
  - \* (as defined in the Certificate and according to Medical and Behavioral Health policies made by Total Health Care with the input of Physicians not employed by Total Health Care or according to reputable sources).
- **Out of Network Services:** Costs associated with services obtained Out of Network (unless services were the result of a Medical Emergency or Accidental Injury or Urgent Condition as defined in your Certificate of Coverage) will not apply towards your Maximum Out of Pocket Expense, nor will they apply towards satisfying your Deductible or Coinsurance.
- **Emergency Services incurred Out of Network:** Co-pays, Deductibles and Coinsurance will apply toward your Total Health Care USA Network obligations. Total Health Care will pay fee screens, Medicare fees or Usual and Customary rates for out of network emergency services, including professional fees and ambulances. Any balance-billing by the provider if they do not agree to accept the reimbursement will be member responsibility.
- If you seek services without a referral and Prior Approval when required, you will be required to pay for the cost of the services. You will also pay for services that are beyond those approved, beyond benefit maximums or excluded from Coverage. You or your Physician must call (313) 871-2000 to obtain Prior Approval for services. Report emergency inpatient admissions to us as soon as reasonably possible after admission.

See Section V of your Certificate for Covered and Non-Covered Services. It includes the summary of Covered Preventive Health Care Services for which you are entitled without any cost share. Total Health Care's complete Preventive Health Care Guidelines are available from our Customer Service Department. Please call (313) 871-2000.

| Services  | Benefit   |
|---|---|
| <b>Hospital Services, including radiology and laboratory services facility fees</b> |   |
| Inpatient Care and Acute Care Services (including delivery of a newborn)            | 30% Coinsurance after Deductible  |
| Hospital Outpatient Care  | 30% Coinsurance after Deductible  |
| Hospital Observation Care   | 30% Coinsurance after Deductible  |
| <b>Medical Emergency &amp; Urgent Care Services</b>                                 |   |
| Emergency Room Services   | 30% Coinsurance after Deductible<br>(subject to additional balance-billing if out of network; refer to COC) |
| Urgent Care Center Services   | 30% Coinsurance after Deductible  |
| Virtual Visits via TELADOC®   | 100% Covered, not subject to Deductible   |
| Emergency Transportation/Ambulance  | 30% Coinsurance after Deductible<br>(subject to additional balance-billing if out of network; refer to COC) |
| <b>Professional Physician Services (Primary &amp; Specialty Care)</b>               |   |
| Office/Home Visits and Consultations (to treat sickness or injury)                  | 30% Coinsurance after Deductible  |
| Telehealth visits from a PCP or Specialist  | 100% Covered  |
| Preventive Health Care Services<br>(See Section V 5.02 of your Certificate)         | 100% Covered  |
| Maternity Services (prenatal, postnatal, maternity education)                       | 100% Covered  |
| Inpatient Hospital Visits   | 30% Coinsurance after Deductible  |
| Inpatient Surgical Procedures (including transplants)                               | 30% Coinsurance after Deductible  |
| Ambulatory Surgery Center Services, Outpatient Surgery                              | 30% Coinsurance after Deductible  |
| Allergy Testing & Serum   | 30% Coinsurance after Deductible  |
| <b>Other Specialty Care</b>   |   |
| Infertility Services (to address underlying causes only)                            | 30% Coinsurance after Deductible  |
| Temporomandibular Joint Dysfunction/Syndrome  | 30% Coinsurance after Deductible  |
| Orthognathic Surgery  | 30% Coinsurance after Deductible  |
| Accidental Dental   | See Orthognathic Surgery Benefit  |

Shading represents a service with a benefit restriction

| Services  | Total Health Care USA Network                    |
|---|--|
| Bariatric Surgery (one per lifetime)  | 30% Coinsurance after Deductible                 |
| Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)  | 30% Coinsurance after Deductible                 |
| Dietician Services/Nutritional Counseling (up to six visits per Contract Year)  | 30% Coinsurance after Deductible                 |
| Diabetes Education Weight Loss Services   | 30% Coinsurance after Deductible<br>100% Covered |
| <b>Behavioral Health Services</b><br>Requires Prior Approval from Behavioral Health Provider, call 855-377-2416   |  |
| Mental Health Inpatient Facility Care (including partial hospitalization and residential facility)  | 30% Coinsurance after Deductible                 |
| Professional Services while Inpatient   | 30% Coinsurance after Deductible                 |
| Mental Health Outpatient Care (includes Group Therapy - Professional Services)  | 30% Coinsurance after Deductible                 |
| Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)   | 30% Coinsurance after Deductible                 |
| Professional Services for Inpatient Substance Use Services  | 30% Coinsurance after Deductible                 |
| Professional Services for Outpatient Substance Use Services   | 30% Coinsurance after Deductible                 |
| Autism ABA Benefits   | 30% Coinsurance after Deductible                 |
| <b>Rehabilitative &amp; Habilitative Medicine Services</b>  |  |
| Rehabilitative: <ul style="list-style-type: none"> <li>• Physical &amp; Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year)</li> <li>• Speech Therapy (30 visits per Contract Year)</li> </ul>                                      | 30% Coinsurance after Deductible                 |
| Habilitative Services: <ul style="list-style-type: none"> <li>• Physical &amp; Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year)</li> <li>• Speech Therapy (30 visits)</li> <li>• Autism: No visit limit for PT/OT, ST</li> </ul> | 30% Coinsurance after Deductible                 |
| Cardiac Rehabilitation & Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)   | 30% Coinsurance after Deductible                 |
| Habilitative & Rehabilitative Devices   | 30% Coinsurance after Deductible                 |

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| Services  | Total Health Care USA Network              |
|---|--|
| <b>Other Services</b>   |  |
| Radiation Therapy   | 30% Coinsurance after Deductible           |
| Dialysis Services   | 30% Coinsurance after Deductible           |
| Chemotherapy<br>Medical Benefit (Doctor Dispensed)<br>Pharmacy Benefit  | 30% Coinsurance after Deductible           |
| Infusion Therapy  | 30% Coinsurance after Deductible           |
| Radiology Examinations (in a non-hospital setting facility)<br>including MRI, MRA, CT, PET Scans  | 30% Coinsurance after Deductible           |
| Laboratory Services   | 30% Coinsurance after Deductible           |
| Prosthetic & Orthotic Support Services  | 30% Coinsurance after Deductible           |
| Durable Medical Equipment for rent, purchase or repair<br>(including oxygen and enteral nutrition products)<br><i>Specific Network Provider</i> | 30% Coinsurance after Deductible           |
| Home Health Care  | 30% Coinsurance after Deductible           |
| Hospice Care  | 30% Coinsurance after Deductible           |
| Eyeglasses on selected lenses & frames<br>Children up to 18 yrs - one pair yearly<br>Adults - not covered                                       | 30% Coinsurance after Deductible           |
| Eye Exam (children only) - one yearly   | 30% Coinsurance after Deductible           |
| Hearing Aid Exam and Hearing Aids   | Not Covered                                |
| Skilled Nursing Facility (up to 45 days maximum per Contract Year)  | 30% Coinsurance after Deductible           |
| IRS Chronic Condition Services and Supplies   | 30% Coinsurance, not subject to Deductible |

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