TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

PLATINUM HMO $500/0%

Cost Share for Medical Expenses	Individual	Family
Annual Deductible	$500	$1,000
Coinsurance	0%	0%
Cost Share for Pharmacy Expenses (Copays apply toward Max Out-of-Pocket; pay Copay or 50% of charges, whichever is less)		
Deductible and Coinsurance	0%	0%
Generic Copay	$10 Copay	$10 Copay
Preferred Brand Copay	$40 Copay	$40 Copay
Non-preferred Brand Copay	$80 Copay	$80 Copay
Specialty Drug Coinsurance	25%	25%
Maximum Out-of-Pocket Expense		
Integrated Medical and Prescription	$7,750	$5,500

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 USA with the input of Physicians not employed by Total Health Care USA or according to reputable source.)

- **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:** Copays, Deductibles, and Coinsurance will apply toward your Total Health Care USA Network obligations. Total Health Care USA 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 USA's complete Preventive Health Care Guidelines are available from our Customer Service Department. Please call (313) 871-2000.

Services	Benefit
Hospital Services, including radiology and laboratory services facility fees	
Inpatient Care and Acute Care Services (including delivery of a newborn)	100% Covered after Deductible
Hospital Outpatient Care	100% Covered after Deductible
Hospital Observation Care	100% Covered after Deductible
Medical Emergency and Urgent Care Services	
Emergency Room Services	$75 Copay (waived if admitted directly from ER) (subject to additional balance-billing if out-of-network; refer to COC)
Urgent Care Center Services	$30 Copay
Emergency Transportation/Ambulance	$75 Copay (subject to additional balance-billing if out-of-network; refer to COC)
Professional Physician Services (Primary and Specialty Care)	
Office/Home Visits and Consultations (to treat sickness or injury)	$15 Copay
Preventive Health Care Services (See Section V 5.02 of your Certificate)	100% Covered
Maternity Services (prenatal, postnatal, maternity education)	100% Covered
Inpatient Hospital Visits	100% Covered after Deductible
Inpatient Surgical Procedures (including transplants)	100% Covered after Deductible
Ambulatory Surgery Center Services, Outpatient Surgery	100% Covered after Deductible
Allergy Testing and Serum	100% Covered
Other Specialty Care	
Infertility Services (to address underlying causes only)	100% Covered after Deductible
Temporomandibular Joint Dysfunction/Syndrome	50% Covered
Orthognathic Surgery	50% Covered
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)	100% Covered after Deductible
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	100% Covered after Deductible
Dietician Services/Nutritional Counseling (up to six visits per Contract Year)	100% Covered
Diabetes Education Weight Loss Services	100% Covered
Behavioral Health Services Requires Prior Approval from Behavioral Health Provider, call (855) 377-2416	
Mental Health Inpatient Facility Care (including partial hospitalization and residential facility)	100% Covered after Deductible
Professional Services while Inpatient	100% Covered after Deductible
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	$15 Copay
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	100% Covered after Deductible
Professional Services for Inpatient Substance Use Services	100% Covered after Deductible
Professional Services for Outpatient Substance Use Services	$15 Copay
Autism ABA Benefits	$15 Copay
Rehabilitative and Habilitative Medicine Services	
Rehabilitative: • Physical and Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year) • Speech Therapy (30 visits per Contract Year)	100% Covered after Deductible
Habilitative Services: • Physical and Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year) • Speech Therapy (30 visits) • Autism: No visit limit for PT/OT, ST	100% Covered after Deductible
Cardiac Rehabilitation and Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	100% Covered after Deductible
Habilitative and Rehabilitative Devices	100% Covered after Deductible

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Services	Total Health Care USA Network
Other Services	
Radiation Therapy	100% Covered after Deductible
Dialysis Services	100% Covered after Deductible
Chemotherapy Medical Benefit (Doctor Dispensed) Pharmacy Benefit	 100% Covered after Deductible 25% Coinsurance
Infusion Therapy	100% Covered after Deductible
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	100% Covered after Deductible
Laboratory Services	100% Covered after Deductible
Prosthetic and Orthotic Support Services	100% Covered after Deductible
Durable Medical Equipment for rent, purchase, or repair (including oxygen and enteral nutrition products) *Specific Network Provider*	100% Covered
Home Health Care	100% Covered after Deductible
Hospice Care	100% Covered after Deductible
Eyeglasses on selected lenses and frames Adults - one pair every 2 years Children up to 18 yrs - one pair yearly	100% Covered
Eye Exam (one yearly)	100% Covered
Hearing Aid Exam and Hearing Aids	100% Coverage for Examination, Plan pays a max $600 per ear every 3 years
Skilled Nursing Facility (up to 45 days maximum per Contract Year)	100% Covered after Deductible

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