TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

TOTAL SILVER HMO $3,500/20%

Cost Share for Medical Expenses	Individual	Family
Annual Deductible	$3,500	$7,000
Coinsurance	20%	20%
Cost Share for Pharmacy Expenses (Co-pays apply toward Max Out of Pocket; pay Co-pay or 50% of charges, whichever is less)		
Deductible (Integrated with Medical)	0%	0%
Generic Co-pay	$20 Co-pay	$20 Co-pay
Preferred Brand Co-pay	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Non-preferred Brand Co-pay	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Specialty Drug Coinsurance	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Maximum Out of Pocket Expense		
Integrated Medical and Prescription	$7,750	$15,500

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 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
Hospital Services, including radiology and laboratory services facility fees	
Inpatient Care and Acute Care Services (including delivery of a newborn)	20% Coinsurance after Deductible
Hospital Outpatient Care	20% Coinsurance after Deductible
Hospital Observation Care	20% Coinsurance after Deductible
Medical Emergency & Urgent Care Services	
Emergency Room Services	$300 Co-pay (subject to additional balance-billing if out of network; refer to COC)
Urgent Care Center Services	20% Coinsurance after Deductible
Virtual Visits via TELADOC©	100% Covered
Emergency Transportation/Ambulance	20% Coinsurance after Deductible (subject to additional balance-billing if out of network; refer to COC)
Professional Physician Services (Primary & Specialty Care)	
Office/Home Visits and Consultations (to treat sickness or injury)	$35 Co-pay Primary Care 20% Coinsurance after Deductible Specialists
Telehealth visits from a PCP or Specialist	100% Covered
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	20% Coinsurance after Deductible
Inpatient Surgical Procedures (including transplants)	20% Coinsurance after Deductible
Ambulatory Surgery Center Services, Outpatient Surgery	20% Coinsurance after Deductible
Allergy Testing & Serum	100% Covered
Other Specialty Care	
Infertility Services (to address underlying causes only)	20% Coinsurance 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)	20% Coinsurance after Deductible
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	20% Coinsurance 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)	20% Coinsurance after Deductible
Professional Services while Inpatient	20% Coinsurance after Deductible
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	20% Coinsurance after Deductible
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	20% Coinsurance after Deductible
Professional Services for Inpatient Substance Use Services	20% Coinsurance after Deductible
Professional Services for Outpatient Substance Use Services	20% Coinsurance after Deductible
Autism ABA Benefits	20% Coinsurance after Deductible
Rehabilitative & Habilitative Medicine Services	
Rehabilitative: • Physical & Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year) • Speech Therapy (30 visits per Contract Year)	20% Coinsurance after Deductible
Habilitative Services: • Physical & 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	20% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	20% Coinsurance after Deductible
Habilitative & Rehabilitative Devices	20% Coinsurance after Deductible

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Services	Total Health Care USA Network
Other Services	
Radiation Therapy	20% Coinsurance after Deductible
Dialysis Services	20% Coinsurance after Deductible
Chemotherapy Medical Benefit (Doctor Dispensed) Pharmacy Benefit	20% Coinsurance after Deductible 20% Coinsurance after Deductible
Infusion Therapy	20% Coinsurance after Deductible
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	20% Coinsurance after Deductible
Laboratory Services	20% Coinsurance after Deductible
Prosthetic & Orthotic Support Services	20% Coinsurance after Deductible
Durable Medical Equipment for rent, purchase or repair (including oxygen and enteral nutrition products) *Specific Network Provider*	100% Covered
Home Health Care	20% Coinsurance after Deductible
Hospice Care	20% Coinsurance after Deductible
Eyeglasses on selected lenses & 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% Covered for Exam Coverage up to $600 maximum per year every 3 years for hearing aid
Skilled Nursing Facility (up to 45 days maximum per Contract Year)	20% Coinsurance after Deductible

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