



**TOTALLY THERE FOR YOU**

## GOLD POS \$1,500/20%

Cost Share for Medical Expenses	Total Health Care USA Network		Cofinity/First Health Network	
	Per Individual	Family	Per Individual	Family
Annual Deductible	\$1,500	\$3,000	\$4,000	\$8,000
Coinsurance	20%	20%	50%	50%
<b>Cost Share for Pharmacy Expenses (Copays apply toward Max Out-of-Pocket; pay Copay or 50% of charges, whichever is less)</b>				
Generic Copay	\$10	\$10	Pharmacy services available exclusively through Total Health Care USA's Affiliated Pharmacy Network except in the case of a Medical Emergency. In-network Copays would apply in those circumstances.	
Preferred Brand Copay	\$40	\$40		
Non-preferred Brand Copay	\$80	\$80		
Specialty Drug Coinsurance	25%	25%		
<b>Maximum Out-of-Pocket Expense</b>				
Integrated Medical and Prescription	\$3,000	\$6,000	\$7,500	\$15,000

### 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 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:** 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	Total Health Care USA Network	Cofinity/First Health Network
<b>Hospital Services, including radiology and laboratory services facility fees</b>		
Inpatient Care and Acute Care Services (including delivery of a newborn)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Outpatient Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Observation Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible
<b>Medical Emergency and Urgent Care Services</b>		
Emergency Room Services	\$150 Copay after Deductible	\$150 Copay after Deductible (subject to additional balance-billing if out of the Cofinity/First Health Network; refer to COC)
Urgent Care Center Services	\$40 Copay	\$75 Copay after Deductible
Emergency Transportation/Ambulance	\$75 Copay	\$75 Copay (subject to additional balance-billing if out of the Cofinity/First Health Network; refer to COC)
<b>Professional Physician Services (Primary and Specialty Care)</b>		
Office/Home Visits and Consultations (to treat sickness or injury)	\$20 Copay Primary Care \$40 Copay Specialist	\$50 Copay after Deductible Primary Care \$75 Copay after Deductible Specialist
Preventive Health Care Services (See Section V 5.02 of your Certificate)	100% Covered	100% Covered
Maternity Services (prenatal, postnatal, maternity education)	100% Covered	100% Covered
Inpatient Hospital Visits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Surgical Procedures (including transplants)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Ambulatory Surgery Center Services, Outpatient Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Allergy Testing and Serum	\$20 Copay	\$50 Copay
<b>Other Specialty Care</b>		
Infertility Services (to address underlying causes only)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Temporomandibular Joint Dysfunction/Syndrome	50% Covered	50% Covered
Orthognathic Surgery	50% Covered	50% Covered
Accidental Dental	See Orthognathic Surgery Benefit	See Orthognathic Surgery Benefit

Shading represents a service with a benefit restriction

Services	Total Health Care USA Network	Cofinity/First Health Network
Bariatric Surgery (one per lifetime)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Dietician Services/Nutritional Counseling (up to six visits per Contract Year)	100% Covered	\$50 Copay
Diabetes Education	100% Covered	100% Covered
Weight Loss Services	100% Covered	Not Covered
<b>Behavioral Health Services</b> —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	50% Coinsurance after Deductible
Professional Services while Inpatient	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	\$40 Copay	\$75 Copay after Deductible
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Professional Services for Inpatient Substance Use Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Professional Services for Outpatient Substance Use Services	\$40 Copay	\$75 Copay after Deductible
Autism ABA Benefits	\$40 Copay	\$75 Copay after Deductible
<b>Rehabilitative and Habilitative Medicine Services</b>		
Rehabilitative: <ul style="list-style-type: none"> <li>Physical and 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>	\$40 Copay	\$75 Copay after Deductible
Habilitative Services: <ul style="list-style-type: none"> <li>Physical and 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>	\$40 Copay	\$75 Copay after Deductible
Cardiac Rehabilitation and Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	\$40 Copay	\$75 Copay after Deductible
Habilitative and Rehabilitative Devices	20% Coinsurance after Deductible	50% Coinsurance after Deductible

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Services	Total Health Care USA Network	Cofinity/First Health Network
<b>Other Services</b>		
Radiation Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Dialysis Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemotherapy Medical Benefit (Doctor Dispensed) Pharmacy Benefit	20% Coinsurance after Deductible 25% Coinsurance	50% Coinsurance after Deductible N/A
Infusion Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthetic and Orthotic Support Services	20% Coinsurance after Deductible	Not Covered
Durable Medical Equipment for rent, purchase, or repair (including oxygen and enteral nutrition products) <i>Specific Network Provider</i>	100% Covered	Not Covered
Home Health Care	20% Coinsurance after Deductible	Not Covered
Hospice Care	20% Coinsurance after Deductible	Not Covered
Eyeglasses on selected lenses and frames Adults - one pair every 2 years Children up to 18 yrs - one pair yearly	100% Covered	Not Covered
Eye Exam (one yearly)	100% Covered	Not Covered
Hearing Aid Exam and Hearing Aids	100% Coverage for Examination, Plan pays a max \$600 per ear every 3 years	Not Covered
Skilled Nursing Facility (up to 45 days maximum per Contract Year)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

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