TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

PLATINUM POS $300/0%

	Total Health Care USA Network		Cofinity/First Health Network	
Cost Share for Medical Expenses	**Per Individual**	**Family**	**Per Individual**	**Family**
Annual Deductible	$300	$600	$900	$1,800
Coinsurance	0%	0%	25%	25%
Cost Share for Pharmacy Expenses (Copays apply toward Max Out-of-Pocket; pay Copay or 50% of charges, whichever is less)				
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%		
Maximum Out-of-Pocket Expense				
Integrated Medical and Prescription	$1,250	$2,500	$3,000	$6,000

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
Hospital Services, including radiology and laboratory services facility fees		
Inpatient Care and Acute Care Services (including delivery of a newborn)	100% Covered after Deductible	25% Coinsurance after Deductible
Hospital Outpatient Care	100% Covered after Deductible	25% Coinsurance after Deductible
Hospital Observation Care	100% Covered after Deductible	25% Coinsurance after Deductible
Medical Emergency and Urgent Care Services		
Emergency Room Services	$125 Copay	$125 Copay (subject to additional balance-billing if out of the Cofinity/ First Health Network; refer to COC)
Urgent Care Center Services	$30 Copay	$80 Copay
Emergency Transportation/Ambulance	$75 Copay	$75 Copay (subject to additional balance-billing if out of the Cofinity/ First Health Network; refer to COC)
Professional Physician Services (Primary and Specialty Care)		
Office/Home Visits and Consultations (to treat sickness or injury)	$15 Copay	$40 Copay
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	100% Covered after Deductible	25% Coinsurance after Deductible
Inpatient Surgical Procedures (including transplants)	100% Covered after Deductible	25% Coinsurance after Deductible
Ambulatory Surgery Center Services, Outpatient Surgery	100% Covered after Deductible	25% Coinsurance after Deductible
Allergy Testing and Serum	$15 Copay	$40 Copay
Other Specialty Care		
Infertility Services (to address underlying causes only)	100% Covered after Deductible	25% 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)	100% Covered after Deductible	25% Coinsurance after Deductible
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	100% Covered after Deductible	25% Coinsurance after Deductible
Dietician Services/Nutritional Counseling (up to six visits per Contract Year)	100% Covered	$40 Copay
Diabetes Education	100% Covered	100% Covered
Weight Loss Services	100% Covered	Not 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	25% Coinsurance after Deductible
Professional Services while Inpatient	100% Covered after Deductible	25% Coinsurance after Deductible
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	$15 Copay	$40 Copay
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	100% Covered after Deductible	25% Coinsurance after Deductible
Professional Services for Inpatient Substance Use Services	100% Covered after Deductible	25% Coinsurance after Deductible
Professional Services for Outpatient Substance Use Services	$15 Copay	$40 Copay
Autism ABA Benefits	$15 Copay	$40 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)	$15 Copay	$40 Copay
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	$15 Copay	$40 Copay
Cardiac Rehabilitation and Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	$15 Copay	$40 Copay
Habilitative and Rehabilitative Devices	100% Covered after Deductible	25% Coinsurance after Deductible

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Services	Total Health Care USA Network	Cofinity/First Health Network
Other Services		
Radiation Therapy	100% Covered after Deductible	25% Coinsurance after Deductible
Dialysis Services	100% Covered after Deductible	25% Coinsurance after Deductible
Chemotherapy Medical Benefit (Doctor Dispensed) Pharmacy Benefit	100% Covered after Deductible 25% Coinsurance	25% Coinsurance after Deductible N/A
Infusion Therapy	100% Covered after Deductible	25% Coinsurance after Deductible
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	100% Covered after Deductible	25% Coinsurance after Deductible
Laboratory Services	100% Covered	100% Covered
Prosthetic and Orthotic Support Services	100% Covered after Deductible	Not Covered
Durable Medical Equipment for rent, purchase, or repair (including oxygen and enteral nutrition products) *Specific Network Provider*	100% Covered	Not Covered
Home Health Care	100% Covered after Deductible	Not Covered
Hospice Care	100% Covered 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)	100% Covered after Deductible	25% Coinsurance after Deductible

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