



TOTALLY YOU 94 SILVER

TOTALLY THERE FOR YOU

Cost Share for Medical Expenses	Individual	Family
Annual Deductible	\$0	\$0
Coinsurance	10%	10%
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	\$0 Copay	\$0 Copay
Preferred Brand Copay	\$20 Copay	\$20 Copay
Non-preferred Brand Copay	\$50 Copay	\$50 Copay
Specialty Drug Coinsurance	50% Coinsurance	50% Coinsurance
Maximum Out-of-Pocket Expense		
Integrated Medical and Prescription	\$2,450	\$4,900

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	Benefit
Hospital Services, including radiology and laboratory services facility fees	
Inpatient Care and Acute Care Services (including delivery of a newborn)	Member pays Coinsurance
Hospital Outpatient Care	Member pays Coinsurance
Hospital Observation Care	Member pays Coinsurance
Transplants	Member pays Coinsurance for Inpatient stay; 100% Covered for Professional Charges after Deductible
Medical Emergency and Urgent Care Services	
Emergency Room Services	Member pays Coinsurance (subject to additional balance-billing if out-of-network; refer to COC)
Urgent Care Center Services	\$20 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)	\$0 Copay Primary Care \$20 Copay Specialist
Preventive Health Care Services (includes Well Baby Visits) (See Section V 5.02 of your Certificate)	100% Covered
Maternity Services (prenatal, postnatal, maternity education)	100% Covered
Inpatient Hospital Visits	Member pays Coinsurance
Inpatient Surgical Procedures (including transplants and their associated care)	Member pays Coinsurance
Ambulatory Surgery Center Services, Outpatient Surgery	Member pays Coinsurance
Allergy Testing and Serum, Injections	100% Covered
Other Specialty Care	
Family Planning (tubal ligation, vasectomy)	100% Covered
Infertility Services (to address underlying causes only)	Member pays Coinsurance
Temporomandibular Joint Dysfunction/Syndrome	50% Covered
Orthognathic Surgery	50% Covered
Accidental Dental	See Certificate of Coverage for Coverage Exceptions

Shading represents a service with a benefit restriction

Services	Total Health Care USA Network
Bariatric Surgery (one per lifetime)	Member pays Coinsurance
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	Member pays Coinsurance
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)	Member pays Coinsurance
Professional Services while Inpatient	Member pays Coinsurance
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	\$20 Copay
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	Member pays Coinsurance
Professional Services for Inpatient Substance Use Services	Member pays Coinsurance
Professional Services for Outpatient Substance Use Services	\$20 Copay
Autism ABA Benefits	\$20 Copay
Rehabilitative and Habilitative Medicine Services	
Rehabilitative: <ul style="list-style-type: none"> • Physical and Occupational Therapy, Chiropractic and Osteopathic Manipulations (combined benefit up to 30 visits per Contract Year) • Speech Therapy (30 visits per Contract Year) 	Member pays Coinsurance
Habilitative Services: <ul style="list-style-type: none"> • 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 	Member pays Coinsurance
Cardiac Rehabilitation and Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	Member pays Coinsurance
Habilitative and Rehabilitative Devices	Member pays Coinsurance

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Services	Total Health Care USA Network
Other Services	
Radiation Therapy	Member pays Coinsurance
Dialysis Services	Member pays Coinsurance
Chemotherapy (Antineoplastic Drug Therapy) Medical Benefit (Doctor Dispensed) Pharmacy Benefit	Member pays Coinsurance 50% Coinsurance
Infusion Therapy	Member pays Coinsurance
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	Member pays Coinsurance
Laboratory Services	Member pays Coinsurance
Prosthetic and Orthotic Support Services	Member pays Coinsurance
Durable Medical Equipment for rent, purchase, or repair (including oxygen and enteral nutrition products) <i>Specific Network Provider</i>	100% Covered
Home Health Care	100% Covered
Hospice Care	100% Covered
Clinical Trial	Member pays Coinsurance
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)	Member pays Coinsurance

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