TOTALLY THERE FOR YOU

TOTALLY YOU SIMPLE CHOICE SILVER

Cost Share for Medical Expenses	Individual	Family
Annual Deductible	$3,500	$7,000
Coinsurance	20%	20%
Cost Share for Pharmacy Expenses (Copays apply toward Max Out-of-Pocket; pay Copay or 50% of charges, whichever is less)		
Deductible is integrated with Medical	$600	$1,200
Generic Copay	$20 Copay	$20 Copay
Preferred Brand Copay	$50 Copay	$50 Copay
Non-preferred Brand Copay	$100 Copay	$100 Copay
Specialty Drug Coinsurance	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Maximum Out-of-Pocket Expense		
Integrated Medical and Prescription	$8,150	$16,300

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 after Deductible
Hospital Outpatient Care	Member pays Coinsurance after Deductible
Hospital Observation Care	Member pays Coinsurance after Deductible
Transplants	Member pays Coinsurance after Deductible for Inpatient stay; 100% Covered for professional charges after Deductible
Medical Emergency and Urgent Care Services	
Emergency Room Services	Member pays Coinsurance after Deductible (subject to additional balance-billing if out-of-network; refer to COC)
Urgent Care Center Services	$75 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)	$30 Copay Primary Care $65 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 after Deductible
Inpatient Surgical Procedures (including transplants and their associated care)	Member pays Coinsurance after Deductible
Ambulatory Surgery Center Services, Outpatient Surgery	Member pays Coinsurance after Deductible
Allergy Testing and Serum, Injections	100% Covered
Other Specialty Care	
Family Planning (tubal ligation, vasectomy) Infertility Services (to address underlying causes only)	100% Covered Member pays Coinsurance after Deductible
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 after Deductible
Plastic/Cosmetic/Reconstructive Surgery (requires Prior Approval and must meet criteria as Medically/Clinically Necessary)	Member pays 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)	Member pays Coinsurance after Deductible
Professional Services while Inpatient	Member pays Coinsurance after Deductible
Mental Health Outpatient Care (includes Group Therapy - Professional Services)	$65 Copay
Substance Use Services (includes facility services for inpatient detox, subacute, intermediate care, residential and outpatient evaluation/therapy)	Member pays Coinsurance after Deductible
Professional Services for Inpatient Substance Use Services	Member pays Coinsurance after Deductible
Professional Services for Outpatient Substance Use Services	$65 Copay
Autism ABA Benefits	$65 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)	Member pays Coinsurance 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	Member pays Coinsurance after Deductible
Cardiac Rehabilitation and Pulmonary Rehab (combined benefit up to 30 visits per Contract Year)	Member pays Coinsurance after Deductible
Habilitative & Rehabilitative Devices	Member pays Coinsurance after Deductible

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Services	Total Health Care USA Network
Other Services	
Radiation Therapy	Member pays Coinsurance after Deductible
Dialysis Services	Member pays Coinsurance after Deductible
Chemotherapy (Antineoplastic Drug Therapy) Medical Benefit (Doctor Dispensed) Pharmacy Benefit	Member pays Coinsurance after Deductible 40% Coinsurance
Infusion Therapy	Member pays Coinsurance after Deductible
Radiology Examinations (in a non-hospital setting facility) including MRI, MRA, CT, PET Scans	Member pays Coinsurance after Deductible
Laboratory Services	Member pays Coinsurance after Deductible
Prosthetic and Orthotic Support Services	Member pays 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	Member pays Coinsurance after Deductible
Hospice Care	Member pays Coinsurance after Deductible
Clinical Trial	Member pays Coinsurance 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)	Member pays Coinsurance after Deductible

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