TOTALLY THERE FOR YOU

SELECT HIGH 09 POS - GRANDFATHERED

	TOTAL HEALTH CARE USA	COFINITY (PPOM) NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE			
	Per Individual Contract $1,000	Per Individual Contract $2,000	Per Individual Contract $3,000
	Per Family Contract $2,000	Per Family Contract $4,000	Per Family Contract $6,000
OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLES AND COINSURANCE)			
	Per Individual Contract $1,000	Per Individual Contract $4,000	Per Individual Contract $15,000
	Per Family Contract $2,000	Per Family Contract $8,000	Per Family Contract $30,000
PERCENTAGE COINSURANCE PAID BY MEMBER			
	0%	25% of Cofinity (PPOM) Rate	50% of Charges
PHYSICIAN SERVICES / PREVENTIVE SERVICES			
Primary care office visits	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Specialist office visits	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Allergy injections	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Chiropractic care (20 visits per year)	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Hearing and vision screening	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Immunizations (pediatric)	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Well child care	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Annual physical exam	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Annual well woman visit	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
PSA screening	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Nutritional counseling and education	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Health education and counseling	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
MATERNITY SERVICES			
Prenatal & postnatal care	$20 Co-pay (one time Co-pay)	$50 Co-pay (one time Co-pay)	Subject to Deductible and Coinsurance
Delivery in hospital	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Well baby care in hospital	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
INPATIENT HOSPITAL SERVICES			
Unlimited days in a semi-private room; surgery, all physicians and other ancillary services; related drug therapy; lab tests and x-rays	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
OUTPATIENT PROCEDURES			
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drug therapy; lab tests and x-rays	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
EMERGENCY MEDICAL SERVICES			
Physician and hospital emergency room services (Co-pay waived if admitted)	$150 Co-pay	$150 Co-pay	$150 Co-pay
Ambulance services (when medically necessary)	$75 Co-pay	$75 Co-pay	$75 Co-pay
AFTER HOURS MEDICAL SERVICES			
Participating after-hours care centers (Urgent Care)	$30 Co-pay	$75 Co-pay	Subject to Deductible and Coinsurance
DIAGNOSTIC & THERAPEUTIC SERVICES			
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Chemotherapy	Subject to Deductible	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Physical, occupational and speech therapy	$20 Co-pay	$50 Co-pay	Subject to Deductible and Coinsurance
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	$20 Co-pay	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Mammograms	Covered	$50 Co-pay	Subject to Deductible and Coinsurance
BEHAVIORAL HEALTH CARE			
Outpatient treatment	Covered	$40 Co-pay	Subject to Deductible and Coinsurance
Inpatient psychiatric hospital services	Covered	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
SUBSTANCE ABUSE TREATMENT			
Outpatient Care	Covered	$50 Co-pay	Subject to Deductible and Coinsurance
Intermediate Care	Covered	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
OTHER SERVICES			
Home Health Care (limited to 100 visits/year)	Covered	Not Covered	Not Covered
Hospice Care	Covered	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Skilled Nursing Care Facility (limited to 120 days per calendar year)	Subject to Total Health Care USA Rider		
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES	Subject to Total Health Care USA Rider		
Covered when medically necessary	Covered	Not Covered	Not Covered
HEARING SERVICES	Subject to Total Health Care USA Rider		
Hearing exam and hearing aid testing	Covered	Not Covered	Not Covered
Hearing aid (limited to one every three years)	Covered	Not Covered	Not Covered
VISION SERVICES	Subject to Total Health Care USA Rider		
Eye exam (limited to one year)	Covered	Not Covered	Not Covered
Eyeglasses (limited to one pair every two years)	Covered	Not Covered	Not Covered
PRESCRIPTION DRUG SERVICES	Subject to Total Health Care USA Rider		
Generic	Refer to Pharmacy Rider	Refer to Pharmacy Rider	Refer to Pharmacy Rider
Brand name	Refer to Pharmacy Rider	Refer to Pharmacy Rider	Refer to Pharmacy Rider

The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement.