



TOTALLY THERE FOR YOU

SELECT MID 09 POS - GRANDFATHERED

TOTAL HEALTH CARE USA

COFINITY (PPOM) NETWORK

OUT-OF-NETWORK

CALENDAR YEAR DEDUCTIBLE

Per Individual Contract	\$300	Per Individual Contract	\$900	Per Individual Contract	\$2,000
Per Family Contract	\$600	Per Family Contract	\$1,800	Per Family Contract	\$4,000

OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLES AND COINSURANCE)

Per Individual Contract	\$300	Per Individual Contract	\$2,000	Per Individual Contract	\$12,500
Per Family Contract	\$600	Per Family Contract	\$4,000	Per Family Contract	\$25,000

PERCENTAGE COINSURANCE PAID BY MEMBER

0%	25% of Cofinity (PPOM) Rate	50% of Charges
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PHYSICIAN SERVICES / PREVENTIVE SERVICES

Primary care office visits	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Specialist office visits	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Allergy injections	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Chiropractic care (20 visits per year)	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Hearing and vision screening	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Immunizations (pediatric)	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Well child care	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Annual physical exam	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Annual well woman visit	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
PSA screening	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Nutritional counseling and education	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Health education and counseling	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance

MATERNITY SERVICES

Prenatal & postnatal care	\$15 Co-pay (one time Co-pay)	\$40 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
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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
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EMERGENCY MEDICAL SERVICES

Physician and hospital emergency room services (Co-pay waived if admitted)	\$125 Co-pay	\$125 Co-pay	\$125 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)	\$25 Co-pay	\$60 Co-pay	Subject to Deductible and Coinsurance
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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	\$15 Co-pay	\$40 Co-pay	Subject to Deductible and Coinsurance
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	\$15 Co-pay	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Mammograms	Covered	\$40 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	\$40 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

Covered when medically necessary	Covered	Not Covered	Not Covered
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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