



TOTALLY THERE FOR YOU



PPN / HMO - GRANDFATHERED

PHYSICIAN PREFERRED NETWORK		TOTAL HEALTH CARE USA	
CALENDAR YEAR DEDUCTIBLE			
Per Individual Contract	\$250	Per Individual Contract	\$500
Per Family Contract	\$650	Per Family Contract	\$1,300

PHYSICIAN SERVICES / PREVENTIVE SERVICES			
Primary care office visits	\$0 Co-pay		\$10 Co-pay
Specialist office visits	\$0 Co-pay		\$10 Co-pay
Allergy injections	\$0 Co-pay		\$10 Co-pay
Chiropractic care (20 visits per year)	\$0 Co-pay		\$10 Co-pay
Hearing and vision screening	\$0 Co-pay		\$10 Co-pay
Immunizations (pediatric)	\$0 Co-pay		\$10 Co-pay
Well child care	\$0 Co-pay		\$10 Co-pay
Annual physical exam	\$0 Co-pay		\$10 Co-pay
Annual well woman visit	\$0 Co-pay		\$10 Co-pay
PSA screening	\$0 Co-pay		\$10 Co-pay
Nutritional counseling and education	\$0 Co-pay		\$10 Co-pay
Health education and counseling	\$0 Co-pay		\$10 Co-pay
MATERNITY SERVICES			
Prenatal & postnatal care	\$0 Co-pay		\$10 Co-pay (one time Co-pay)
Delivery in hospital	Deductible		Deductible
Well baby care in hospital	Covered		Covered
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	Deductible		Deductible
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	Deductible		Deductible
EMERGENCY MEDICAL SERVICES			
Physician and hospital emergency room services (Co-pay waived if admitted)	\$100 Co-pay		\$100 Co-pay
Ambulance services (when medically necessary)	\$75 Co-pay		\$75 Co-pay
AFTER HOURS MEDICAL SERVICES			
Participating after-hours care centers (Urgent Care)	\$25 Co-pay		\$25 Co-pay
DIAGNOSTIC & THERAPEUTIC SERVICES			
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Deductible		Deductible
Chemotherapy	Deductible		Deductible
Physical, occupational and speech therapy (limited to 45 days per year)	\$0 Co-pay		\$10 Co-pay
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	\$0 Co-pay		\$10 Co-pay
Mammograms	Covered		Covered
BEHAVIORAL HEALTH CARE			
Outpatient treatment	Covered		Covered
Inpatient psychiatric hospital services	Deductible		Deductible
SUBSTANCE ABUSE TREATMENT			
Outpatient Care	Covered		Covered
Intermediate Care	Deductible		Deductible
OTHER SERVICES			
Home Health Care (limited to 100 visits/year)	Covered		Covered
Hospice Care	Covered		Covered
SKILLED NURSING CARE FACILITY			
limited to 120 days per year	Covered	Subject to Total Health Care USA Rider	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES			
Covered when medically necessary	Covered	Subject to Total Health Care USA Rider	Covered
HEARING SERVICES			
Hearing exam and hearing aid testing	Covered	Subject to Total Health Care USA Rider	Covered
Hearing aid (limited to one every three years)	Covered		Covered
VISION SERVICES			
Eye exam (limited to one year)	Covered	Subject to Total Health Care USA Rider	Covered
Eyeglasses (limited to one pair every two years)	Covered		Covered
PRESCRIPTION DRUG SERVICES			
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy		\$10/Generic \$20/Brand Name*	
*When NO Generic equivalent is available			

The benefits described above are intended to be only a summary description. For details, please review the Certificate of Coverage Agreement. Physician Preferred Network powered by United Outstanding Physicians.