TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

T300 DEDUCTIBLE BENEFIT PLAN T323X - GRANDFATHERED

SUMMARY OF BENEFITS AND COVERAGE	T323X
CALENDAR YEAR DEDUCTIBLE	$500 Individual Contract/$1,300 Family Contract
OUT-OF-POCKET MAXIMUMS (INCLUDES DEDUCTIBLES)	N/A
PHYSICIAN SERVICES / PREVENTIVE SERVICES	**MEMBER ONLY PAYS ONE CO-PAY PER OFFICE VISIT**
Primary care office visits	$15 Co-pay
Specialist office visits	$15 Co-pay
Allergy injections	$15 Co-pay
Chiropractic care (20 visits per year)	$15 Co-pay
Hearing and vision screening	$15 Co-pay
Immunizations (pediatric)	$15 Co-pay
Well child care	$15 Co-pay
Annual physical exam	$15 Co-pay
Annual well woman visit	$15 Co-pay
PSA screening	$15 Co-pay
Nutritional counseling and education	$15 Co-pay
Health education and counseling	$15 Co-pay
MATERNITY SERVICES	
Prenatal & postnatal care	$15 Co-pay (one time Co-pay)
Delivery in hospital	Subject to Deductible
Well baby care in hospital	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	Subject to Deductible
OUTPATIENT PROCEDURES	
Surgery and all invasive procedures conducted in any outpatient setting, including physicians and other ancillary services; related drugtherapy; lab tests and x-rays	Subject to Deductible
EMERGENCY MEDICAL SERVICES	
Physician and hospital emergency room services (Co-pay waived if admitted)	$40 Co-pay
Ambulance services (when medically necessary)	$75 Co-pay
AFTER HOURS MEDICAL SERVICES	
Participating after-hours care centers (Urgent Care)	Covered
DIAGNOSTIC & THERAPEUTIC SERVICES	
Outpatient lab tests; diagnostic x-rays; and radiation therapy at a hospital	Subject to Deductible
Chemotherapy	Subject to Deductible
Physical, occupational and speech therapy	Subject to Deductible
Non-preventative diagnostics including lab, x-ray, pathology, and special diagnostics in a non-hospital setting	Subject to Deductible
Mammograms	Covered
BEHAVIORAL HEALTH CARE	
Outpatient treatment	Covered
SUBSTANCE ABUSE TREATMENT	
Outpatient Care	Covered
Intermediate Care	Subject to Deductible
OTHER SERVICES	
Home Health Care (limited to 100 visits/year)	Covered
Hospice Care	Covered
DURABLE MEDICAL EQUIPMENT / PROSTHETIC DEVICES	
Covered when medically necessary	Covered
PRESCRIPTION DRUG SERVICES	
Formulary medications prescribed by a THC participating provider and through a THC participating pharmacy *When NO Generic equivalent is available	$10/Generic $20/Brand Name*

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

TOTAL HEALTH CARE USA

OCCUPATIONAL EYEWEAR NETWORK, INC

Vision Plan Program

ITEM:	MEMBER PAYS:
Comprehensive Eye Exam	Covered
Contact Lens Fitting Fee	Retail
FRAMES	
Frames (Up to $80.00 Retail)	Covered
Frames (Over $80.00 Retail)	Retail, less 30%, less $24.00
LENSES (CR-39 or Glass)	
Single Vision	Covered
Bifocal	Covered
Trifocal	Covered
CONTACT LENSES	
Elective	Retail, less $80.00
Medically Necessary	Retail, less $140.00

Options available to eligible Total Health Care USA Commercial Groups Members:

ITEM:	MEMBER PAYS:
Polycarbonate Lenses	$30.00
Hi Index	$60.00
Progressive – Standard	$50.00
Progressive – Midrange	$80.00
Progressive – Premium	$125.00
Solid Tint	$10.00
Gradient Tint	$12.00
Oversize Lenses	$0
UV Coating	$15.00
Scratch Coat	$15.00
AR Coating – Standard	$40.00
AR Coating – Premium	$55.00
AR Coating – Hydrophobics	$79.00
Photochromic Lenses	$20.00
Transition Lenses	$70.00
Polarized Lenses	$70.00

AUTHORIZATION:

- Please call OEN customer service toll-free number at (877) 799-0220 to verify eligibility.

NOTES:

- For any item not listed above: Give a 20% discount off retail pricing.
- Progressive Upgrade: Bill Plan for trifocal reimbursement.
- Utilize optical lab of choice for lens fabrication.
- Contact lens benefit is in lieu of eyeglass benefit.
- A prior authorization is required for medically necessary contact lenses.

ELIGIBILITY – All eligible Members are entitled to:

- Examination – every calendar year.
- Frames and Lenses, or Contacts – every two calendar years.

EXCLUSIONS – No payment will be made for the following:

- Eyeglasses for Members not requiring corrective lenses.
- Charges for any service or materials not covered by this program.
- Medical or surgical treatment.
- Services provided or glasses ordered before Member is eligible for coverage or after termination of coverage.
- Replacement of lost lenses or frames, unless Member meets all eligibility requirements.
- Replacement of scratched lenses.
- Prescription safety glasses.