TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

Total Saver Complete HMO - Bronze

Benefit Information	Total Saver Complete HMO Base Plan	Total Saver Complete HMO Zero CS	Total Saver Complete HMO Limited CS
MEDICAL			
Deductible: Annual per Individual/Family Deductibles are Embedded	$7,850/$15,700	$0/$0	$7,850/$15,700
Coinsurance	0%	0%	0%
PHARMACY			
Annual Deductible	Pharmacy Deductible is Integrated with Medical	Pharmacy Deductible is Integrated with Medical	Pharmacy Deductible is Integrated with Medical
Coinsurance	0%	0%	0%
Integrated Medical and Rx MOOP: Annual per Individual/Family MOOPs are Embedded	$7,850/$15,700	$0/$0	$7,850/$15,700
BENEFITS			
Primary Care Visit	$35 Copay	$0 Copay	$35 Copay
Virtual Care Visits with Teledoc®	$0 Copay	$0 Copay	$0 Copay
Specialty Care	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Other Practitioner	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Outpatient Facility Fee	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Outpatient Surgery Physician/Surgical Services	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Hospice Services	100% Coverage after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days	100% Coverage after Deductible NO Benefit Maximum Days
Infertility Treatment – Underlying Causes Only	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Routine Eye Exam (Adult)	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage
Urgent Care	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Home Health Care	100% Coverage after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days	100% Coverage after Deductible NO Benefit Maximum Days
Emergency Room	100% Coverage after Deductible	$0 Copay per Visit	100% Coverage after Deductible
Emergency Ambulance	$75 Copay	$0 Copay	$75 Copay
Inpatient Stay	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Inpatient Physician and Surgical Services	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible

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Bariatric Surgery	100% Coverage after Deductible/ 1 Procedure per Lifetime	100% Coverage/ 1 Procedure per Lifetime	100% Coverage after Deductible/ 1 Procedure per Lifetime
Cosmetic Surgery	100% Coverage after Deductible (when Medically Necessary)	100% Coverage (when Medically Necessary)	100% Coverage after Deductible (when Medically Necessary)
Skilled Nursing Facility	100% Coverage after Deductible up to Benefit Maximum of 45 Days per Contract Year	100% Coverage up to Benefit Maximum of 45 Days per Contract Year	100% Coverage after Deductible up to Benefit Maximum of 45 Days per Contract Year
Prenatal and Postnatal Care	100% Coverage	100% Coverage	100% Coverage
Delivery and All Inpatient Services for Maternity Care	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Mental/Behavioral Health Outpatient Services	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Mental/Behavioral Health Inpatient Services	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Substance Abuse Outpatient	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Substance Abuse Inpatient	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Outpatient Rehabilition Services – Cardiac/ Pulmonary	100% after Deductible up to a Combined Max of 30 Visits per Contract Year	100% Coverage up to a Combined Benefit of 30 Visits per Contract Year	100% after Deductible up to a Combined Max of 30 Visits per Contract Year
Habilitation Services	100% Coverage after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	100% Coverage - PT/OT 30 Combined Visits, ST - 30 Visits	100% Coverage after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits
Chiropractic Care	100% Coverage after Deductible - PT/OT/Chiro 30 Visits Combined Max	100% Coverage - PT/OT/ Chiro 30 Visits Combined Max	100% Coverage after Deductible - PT/OT/Chiro 30 Visits Combined Max
DME (Durable Medical Equipment)	100% Coverage from Plan's DME Provider	100% Coverage from Plan's DME Provider	100% Coverage from Plan's DME Provider
Hearing Aids	100% Coverage after Deductible/ Max $600 per Ear Every 3 Years	100% Coverage/ Max $600 per Ear Every 3 Years	100% Coverage after Deductible/ Max $600 per Ear Every 3 Years
Imaging (CT/PET Scans, MRIs)	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Preventive Care/Screening/Immunizations	100% Coverage	100% Coverage	100% Coverage
Comprehensive Physical	100% Coverage	100% Coverage	100% Coverage
Weight Loss Programs	100% Coverage	100% Coverage	100% Coverage
Routine Eye Exam (Pediatric)	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage
Eye Glasses for Children	Glasses and Frames - 100% Coverage on Selected Lenses and Frames	Glasses and Frames - 100% Coverage on Selected Lenses and Frames	Glasses and Frames - 100% Coverage on Selected Lenses and Frames
Rehabilitative Speech Therapy	100% Coverage after Deductible up to a Max of 30 Visits per Contract Year	100% Coverage up to a Max of 30 Visits per Contract Year	100% Coverage after Deductible up to a Max of 30 Visits per Contract Year
PT/OT	100% after Deductible - PT/OT/Chiro 30 Visits Combined Max	100% Coverage - PT/OT/ Chiro 30 Visits Combined Max	100% after Deductible - PT/OT/Chiro 30 Visits Combined Max
Well Baby Visits	100% Coverage	100% Coverage	100% Coverage

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Laboratory Outpatient and Professional Services	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
X-Rays and Diagnostic Imaging	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Transplant	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Accidental Dental – Included in THC Oral Surgery Benefit	Not Covered	Not Covered	Not Covered
Dialysis	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Allergy Testing	100% Coverage	100% Coverage	100% Coverage
Chemotherapy	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Radiation Therapy	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Diabetes Education	100% Coverage	100% Coverage	100% Coverage
Prosthetic Devices	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Infusion Therapy	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Temporomandibular Joint Disorders	50% Coverage	100% Coverage	50% Coverage
Nutritional Counseling	100% Coverage	100% Coverage	100% Coverage
Reconstructive Surgery	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Mental Health Other	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Prescription Drugs Other	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Eye Glasses for Adults	Glasses and Frames - 100% Coverage on Selected Lenses and Frames	Glasses and Frames - 100% Coverage on Selected Lenses and Frames	Glasses and Frames - 100% Coverage on Selected Lenses and Frames
Rehabilitative Devices	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
Habilitative Devices	100% Coverage after Deductible	100% Coverage	100% Coverage after Deductible
PHARMACY COPAYS			
Generic Copay	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Preferred Brand	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Non-Preferred Brand	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible
Specialty	100% Coverage after Deductible	$0 Copay	100% Coverage after Deductible

This is intended to be an easy-to-read summary of benefits for illustrative purposes only – please reference SOPE for plan and network details.

This exhibit is valid for quoting Total Health Care Individual plans during the Open Enrollment Period (OEP) of November 1, 2020 - December 15, 2020 and during the Special Enrollment Period (SEP) starting December 16, 2020.

These plans are effective January 1, 2021.