TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

Totally You HMO - Silver

Benefit Information	Totally You HMO Base Plan	Totally You HMO Zero CS	Totally You HMO Limited CS	Totally You HMO 73	Totally You HMO 87	Totally You HMO 94
MEDICAL						
Deductible: Annual per Individual/Family Deductibles are Embedded	$4,450/$8,900	$0/$0	$4,450/$8,900	$4,200/$8,400	$950/$1,900	$0/$0
Coinsurance	30%	0%	30%	30%	15%	10%
PHARMACY						
Annual Deductible	$0 per Member	$0 per Member	$0 per Member	$0 per Member	$0 per Member	$0 per Member
Coinsurance	0%	0%	0%	0%	0%	0%
Integrated Medical and Rx MOOP: Annual per Individual/Family MOOPs are Embedded	$8,550/$17,100	$0/$0	$8,550/$17,100	$6,800/$13,600	$2,850/$5,700	$2,450/$4,900
BENEFITS						
Primary Care Visit	$30 Copay	$0 Copay	$30 Copay	$30 Copay	$15 Copay	$0 Copay
Virtual Care Visits with Teledoc®	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Specialty Care	$60 Copay	$0 Copay	$60 Copay	$60 Copay	$35 Copay	$20 Copay
Other Practitioner	$60 Copay	$0 Copay	$60 Copay	$60 Copay	$35 Copay	$20 Copay
Outpatient Facility Fee	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Outpatient Surgery Physician/ Surgical Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Hospice Services	30% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days	30% Coinsurance after Deductible NO Benefit Maximum Days	30% Coinsurance after Deductible NO Benefit Maximum Days	15% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days
Infertility Treatment – Underlying Causes Only	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Routine Eye Exam (Adult)	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage
Urgent Care	$70 Copay	$0 Copay	$70 Copay	$60 Copay	$30 Copay	$20 Copay
Home Health Care	30% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days	30% Coinsurance after Deductible NO Benefit Maximum Days	30% Coinsurance after Deductible NO Benefit Maximum Days	15% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage NO Benefit Maximum Days
Emergency Room	30% Coinsurance after Deductible	$0 Copay per Visit	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Emergency Ambulance	$75 Copay	$0 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay
Inpatient Stay	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance

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Bariatric Surgery	30% Coinsurance after Deductible/ 1 Procedure per Lifetime	100% Coverage/ 1 Procedure per Lifetime	30% Coinsurance after Deductible/ 1 Procedure per Lifetime	30% Coinsurance after Deductible/ 1 Procedure per Lifetime	15% Coinsurance after Deductible/ 1 Procedure per Lifetime	10% Coinsurance after Deductible/ 1 Procedure per Lifetime
Cosmetic Surgery	30% Coinsurance after Deductible (when Medically Necessary)	100% Coverage (when Medically Necessary)	30% Coinsurance after Deductible (when Medically Necessary)	30% Coinsurance after Deductible (when Medically Necessary)	15% Coinsurance after Deductible (when Medically Necessary)	10% Coinsurance after Deductible (when Medically Necessary)
Skilled Nursing Facility	30% Coinsurance after Deductible up to the Benefit Maximum of 45 Days per Contract Year	100% Coverage up to the Benefit Maximum of 45 Days per Contract Year	30% Coinsurance after Deductible up to the Benefit Maximum of 45 Days per Contract Year	30% Coinsurance after Deductible up to the Benefit Maximum of 45 Days per Contract Year	15% Coinsurance after Deductible up to the Benefit Maximum of 45 Days per Contract Year	10% Coinsurance after Deductible up to the Benefit Maximum of 45 Days per Contract Year
Prenatal and Postnatal Care	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Mental/Behavioral Health Outpatient Services	$60 Copay	$0 Copay	$60 Copay	$60 Copay	$35 Copay	$20 Copay
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Substance Abuse Outpatient	$60 Copay	$0 Copay	$60 Copay	$60 Copay	$35 Copay	$20 Copay
Substance Abuse Inpatient	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Outpatient Rehabilition Services – Cardiac/Pulmonary	30% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	100% Coverage up to a Combined Benefit of 30 Visits per Contract Year	30% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	30% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	15% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	10% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year
Habilitation Services	30% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	100% Coverage - PT/OT 30 Combined Visits, ST - 30 Visits	30% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	30% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	15% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	10% Coinsurance - PT/OT 30 Combined Visits, ST - 30 Visits
Chiropractic Care	30% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	100% Coverage - PT/OT/Chiro 30 Visits Combined Max	30% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	30% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	15% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	10% Coinsurance 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	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	100% Coverage after Deductible/ Max $600 per Ear Every 3 Years	100% Coverage after Deductible/ Max $600 per Ear Every 3 Years	100% Coverage/ Max $600 per Ear Every 3 Years
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Preventive Care/Screening/ Immunizations	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Comprehensive Physical	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Weight Loss Programs	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage

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Routine Eye Exam (Pediatric)	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	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	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	30% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	100% Coverage up to a Max of 30 Visits per Contract Year	30% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	30% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	15% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	10% Coinsurance up to a Max of 30 Visits per Contract Year
PT/OT	30% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	100% Coverage - PT/OT/Chiro 30 Visits Combined Max	30% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	30% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	15% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	10% Coinsurance - PT/OT/Chiro 30 Visits Combined Max
Well Baby Visits	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
X-Rays and Diagnostic Imaging	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Transplant	Hospital - Member pays 30% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	100% Coverage	Hospital - Member pays 30% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	Hospital - Member pays 30% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	Hospital - Member pays 15% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	Hospital - Member pays 10% Coinsurance/ Physician In-Patient Visits - 100% Coverage
Accidental Dental – Included in THC Oral Surgery Benefit	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Dialysis	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Allergy Testing	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Chemotherapy	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Radiation Therapy	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Diabetes Education	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Prosthetic Devices	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Infusion Therapy	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Temporomandibular Joint Disorders	50% Coverage	100% Coverage	50% Coverage	50% Coverage	50% Coverage	50% Coverage
Nutritional Counseling	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Reconstructive Surgery	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Mental Health Other	$60 Copay	$0 Copay	$60 Copay	$60 Copay	$35 Copay	$20 Copay
Prescription Drugs Other	50% Coinsurance	$0 Copay	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance

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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	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	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
Habilitative Devices	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	30% Coinsurance after Deductible	15% Coinsurance after Deductible	10% Coinsurance
PHARMACY COPAYS						
Generic Copay	$25 Copay or 50% Whichever Is Less	$0 Copay	$25 Copay or 50% Whichever Is Less	$25 Copay or 50% Whichever Is Less	$15 Copay or 50% Whichever Is Less	$0 Copay
Preferred Brand	$50 Copay or 50% Whichever Is Less	$0 Copay	$50 Copay or 50% Whichever Is Less	$50 Copay or 50% Whichever Is Less	$30 Copay or 50% Whichever Is Less	$20 Copay or 50% Whichever Is Less
Non-Preferred Brand	$100 Copay or 50% Whichever Is Less	$0 Copay	$100 Copay or 50% Whichever Is Less	$100 Copay or 50% Whichever Is Less	$50 Copay or 50% Whichever Is Less	$50 Copay or 50% Whichever Is Less
Specialty	50% Coinsurance	$0 Copay	50% Coinsurance	50% Coinsurance	50% Coinsurance	50% Coinsurance

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.