TOTAL HEALTH CARE USA

TOTALLY THERE FOR YOU

Totally You Value HMO - Silver

Benefit Information	Totally You Value HMO Base Plan	Totally You Value HMO Zero CS	Totally You Value HMO Limited CS	Totally You Value HMO 73	Totally You Value HMO 87	Totally You Value HMO 94
MEDICAL						
Deductible: Annual per Individual/Family Deductibles are Embedded	$5,000/$10,000	$0/$0	$5,000/$10,000	$3,300/$6,600	$975/$1,950	$250/$500
Coinsurance	30%	0%	30%	20%	10%	5%
PHARMACY						
Annual Deductible	Pharmacy Deductible Is Integrated with Medical	Pharmacy Deductible Is Integrated with Medical	Pharmacy Deductible Is Integrated with Medical	Pharmacy Deductible Is Integrated with Medical	Pharmacy Deductible Is Integrated with Medical	Pharmacy Deductible Is Integrated with Medical
Coinsurance	0%	0%	0%	0%	0%	0%
Integrated Medical and Rx MOOP: Annual per Individual/Family MOOPs are Embedded	$7,900/$15,800	$0/$0	$7,900/$15,800	$6,800/$13,600	$2,850/$5,700	$2,600/$5,200
BENEFITS						
Primary Care Visit	$20 Copay	$0 Copay	$20 Copay	$20 Copay	$20 Copay	$5 Copay
Virtual Care Visits with Teledoc®	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Specialty Care	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Other Practitioner	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Outpatient Facility Fee	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage up to Benefit Maximum of 45 Days per Contract Year	30% Coinsurance after Deductible NO Benefit Maximum Days	20% Coinsurance after Deductible NO Benefit Maximum Days	10% Coinsurance after Deductible NO Benefit Maximum Days	5% Coinsurance after Deductible NO Benefit Maximum Days
Infertility Treatment – Underlying Causes Only	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Routine Eye Exam (Adult)	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage	Vision - 100% Coverage
Urgent Care	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Home Health Care	30% Coinsurance after Deductible NO Benefit Maximum Days	100% Coverage up to Benefit Maximum of 45 Days per Contract Year	30% Coinsurance after Deductible NO Benefit Maximum Days	20% Coinsurance after Deductible NO Benefit Maximum Days	10% Coinsurance after Deductible NO Benefit Maximum Days	5% Coinsurance after Deductible NO Benefit Maximum Days
Emergency Room	30% Coinsurance after Deductible	$0 Copay per Visit	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible

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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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Bariatric Surgery	30% Coinsurance after Deductible/ 1 Procedure per Lifetime	100% Coverage/ 1 Procedure per Lifetime	30% Coinsurance after Deductible/ 1 Procedure per Lifetime	20% Coinsurance after Deductible/ 1 Procedure per Lifetime	10% Coinsurance after Deductible/ 1 Procedure per Lifetime	5% 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)	20% Coinsurance after Deductible (when Medically Necessary)	10% Coinsurance after Deductible (when Medically Necessary)	5% 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	20% 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	5% 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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	$20 Copay	$0 Copay	$20 Copay	$20 Copay	$20 Copay	$5 Copay
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Substance Abuse Outpatient	$20 Copay	$0 Copay	$20 Copay	$20 Copay	$20 Copay	$5 Copay
Substance Abuse Inpatient	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Outpatient Rehabilition Services – Cardiac/Pulmonary	30% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	100% Coverage	30% Coinsurance after Deductible up to a Benefit Maximum of 30 Visits per Contract Year	20% 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	5% 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	30% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	20% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	10% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits	5% Coinsurance after Deductible - PT/OT 30 Combined Visits, ST - 30 Visits
Chiropractic Care	30% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	100% Coverage up to a Combined Benefit of 30 Visits per Contract Year	30% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	20% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	10% Coinsurance after Deductible PT/OT/Chiro 30 Visits Combined Max	5% Coinsurance 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	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 after Deductible/ Max $600 per Ear Every 3 Years

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Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
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
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	20% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	10% Coinsurance after Deductible up to a Max of 30 Visits per Contract Year	5% Coinsurance after Deductible 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 up to a Combined Benefit of 30 Visits per Contract Year	30% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	20% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	10% Coinsurance after Deductible - PT/OT/Chiro 30 Visits Combined Max	5% Coinsurance after Deductible - 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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
X-Rays and Diagnostic Imaging	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
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 20% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	Hospital - Member pays 10% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible	Hospital - Member pays 5% Coinsurance after Deductible/ Physician In-Patient Visits - 100% Coverage after Deductible
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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Radiation Therapy	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Infusion Therapy	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Temporomandibular Joint Disorders	50% Coverage	100% Coverage	50% Coverage	50% Coverage	50% Coverage	50% Coverage

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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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Mental Health Other	$20 Copay	$0 Copay	$20 Copay	$20 Copay	$20 Copay	$5 Copay
Prescription Drugs Other	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance 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	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	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Habilitative Devices	30% Coinsurance after Deductible	100% Coverage	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
PHARMACY COPAYS						
Generic Copay	$10 Copay or 50% Whichever Is Less	$0 Copay	$10 Copay or 50% Whichever Is Less	$10 Copay or 50% Whichever Is Less	$5 Copay or 50% Whichever Is Less	100% Coverage - No Cost Sharing
Preferred Brand	$40 Copay after Deductible	$0 Copay	$40 Copay after Deductible	$40 Copay after Deductible	$30 Copay after Deductible	$15 Copay after Deductible
Non-Preferred Brand	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance after Deductible
Specialty	30% Coinsurance after Deductible	$0 Copay	30% Coinsurance after Deductible	20% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance 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.