




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.THCMi.com](http://www.THCMi.com) or call Customer Service at 1-800-826-2862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-826-2862 to request a copy.

IMPORTANT QUESTIONS	ANSWERS	WHY THIS MATTERS:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>Tier 1 Network:</p> <p>Tier 2 Network:</p> <p><u>Deductible</u> does not apply to <u>preventive</u> care.</p> <p>Out of Network: N/A</p>	<p>See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.</p> <p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p>Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p>Tier 1 Network:</p> <p>Tier 2 Network:</p> <p>Out of Network: N/A</p> <p>Combined for medical &amp; pharmacy</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p><u>Premiums</u>, <u>balance-billing</u> charges and health care this <u>plan</u> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

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<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.THCMi.com">www.THCMi.com</a> or call <b>1-800-826-2862</b> for a list of <u>participating providers</u> .	You pay the least if you use a <u>provider</u> in Total Health Care Tier 1 <u>Network</u> . You pay more if you use a provider in Cofinity Tier 2 Network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ).
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes, Chiropractic/Podiatry visits require written PCP <u>referral</u> .	This <u>plan</u> will pay some or all of the costs to see a Chiropractic or Podiatric <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness		Not covered	-----None-----
	<u>Specialist</u> visit		Not covered	-----None-----
	<u>Preventive care/screening/immunization</u>	100% Coverage	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)		Not covered	Tests performed in an outpatient hospital are subject to <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)		Not covered	Written PCP <u>referral</u> required. Tests performed in an outpatient hospital are subject to <u>deductible</u> .

\*For more information about limitations and exceptions, see the plan or policy document at [www.THCMi.com](http://www.THCMi.com).

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="https://thcmi.com/pharmacy/">https://thcmi.com/pharmacy/</a>	Generic drugs (Tier 1)		Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Preferred brand drugs (Tier 2)		Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Non-preferred brand drugs (Tier 3)		Not covered	<u>Prior authorization</u> and step therapy apply to select drugs. Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	<u>Specialty drugs</u> (Tier 4)		Not covered	<u>Prior authorization</u> and step therapy apply to select drugs. Retail Prescription: up to 30 day supply Mail Order: 90 day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)		Not covered	Written PCP <u>referral</u> required
	Physician/surgeon fees		Not covered	Written PCP <u>referral</u> required
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>			-Out of network may be subject to additional balance billing.
	<u>Emergency medical transportation</u>			When medically necessary
	<u>Urgent care</u>		Not covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)		Not covered	<u>Prior approval</u> required
	Physician/surgeon fees		Not covered	<u>Prior approval</u> required
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services		Not covered	<u>Prior approval</u> required
	Inpatient services		Not covered	<u>Prior approval</u> required

\*For more information about limitations and exceptions, see the plan or policy document at [www.THcMi.com](http://www.THcMi.com).

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
<b>If you are pregnant</b>	Office visits	100% Coverage	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services		Not covered	Depending on the type of services, a [ <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> ] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services		Not covered	No prior authorization required for hospital stays for a mother & her newborn of up to 48 hrs following vaginal delivery & 96 hrs following cesarean section
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>		Not covered	<u>Prior approval</u> required
	<u>Rehabilitation services</u>		Not covered	<u>Prior approval</u> required. Physical & Occupational Therapy (including Osteopathic and Chiropractic Manipulation) limited to a combined 30 visits/year. Speech Therapy limited to 30 visits/year. Cardiac & Pulmonary Rehab limit to a combined 30 visits/year.
	<u>Habilitation services</u>		Not covered	<u>Prior approval</u> required
	<u>Skilled nursing care</u>		Not covered	<u>Prior approval</u> required for Skilled Nursing Care, Inpatient Rehabilitative Services and Sub Acute Care. Limit to 45 days per calendar year.
	<u>Durable medical equipment</u>		Not covered	Authorization requirements change frequently. To determine if a service requires authorization, log into <a href="http://www.THCMi.com">www.THCMi.com</a> .
	<u>Hospice services</u>		Not covered	<u>Prior approval</u> required. Includes Inpatient and Outpatient hospice care.
<b>If your child needs dental or eye care</b>	Children's eye exam		Not covered	1 exam per year
	Children's glasses		Not covered	1 pair per year up to age 18. Limited to 1 pair every 2 years for adults 18 and over.
	Children's dental check-up	Not covered	Not covered	-----None-----

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.THCMi.com](http://www.THCMi.com).

## Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services, PO Box 30220, Lansing, MI 48909-7720, Phone No. 1-877-999-6442 or Department of Labor's Employee Benefits Security Administration at 1-866-444-3272. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Total Health Care USA, 3011 W. Grand Blvd. Ste. 1600, Detroit, MI 48202, Phone No. 1-800-826-6442 or: Department of Insurance and Financial Services, PO Box 30220, Lansing, MI 48909-7720, Phone No. 1-877-999-6442.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Total Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Total Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Total Health Care:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Total Health Care at (800) 826-2862, 24 hours a day, seven days a week. TTY users call 711.

If you believe that Total Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Total Health Care Civil Rights Coordinator, 3011 W. Grand Blvd, Suite 1600, Detroit MI 48202, (800) 826-2862 (TDD/TTY: 711), Fax: (800) 826-6406 or email: [thc@thcmi.com](mailto:thc@thcmi.com).
- You can file a grievance by mail, fax or email. If you need help filing a grievance, Total Health Care Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at: [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

English: ATTENTION: If you speak English, language assistance services, at no cost, are available to you. Call (800) 826-2862 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 826-2862 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم رقم هاتف الصم والبكم: (800) 826-2862 --(TTY: 711).

Chinese Mandarin: 注意: 如果您说中文普通话/国语, 我们可为您提供免费语言援助服务。请致电: (800) 286-2862 (TTY: 711)。

Chinese Cantonese: 注意: 如果您使用粵語, 您可以免費獲得語言援助服務。請致電 (800) 826-2862 (TTY: 711)。

Syriac: ܡܠܚܘܙܬܐ: ܐܕܐ ܟܘܢܬܐ ܬܘܚܕܘܬܐ ܠܠܘܓܐ ܥܘܪܝܝܬܐ, ܐܢܐ ܚܘܕܘܬܐ ܠܠܘܓܐ ܥܘܪܝܝܬܐ ܒܠܘܥܝܢܐ. ܐܬܘܘܠ ܒܩܘܡܐ ܩܘܡܐܬܐ ܕܐܠܘܡܐ ܘܕܐܠܘܡܐ: (800) 826-2862. (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 826-2862 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (800) 826-2862 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 826-2862 (TTY: 711) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নথিভাষা সহায়তা পরষিবো উপলবধ আছে। ফোন করুন ১ (৪০০) ৮২৬-২৮৬২ (TTY: ৭১১)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 826-2862 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 826-2862 (TTY: 711)

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 826-2862 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。(800) 826-2862 (TTY: 711)まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 826-2862 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 826-2862 (TTY-711 Telefon za osobe sa oštećenim govorom ili sluhom).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 826-2862 (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)	
<ul style="list-style-type: none"> <li>▪ <b>The <u>plan's</u> overall <u>deductible</u></b></li> <li>▪ <b><u>Specialist</u></b></li>   <li>▪ <b>Hospital (facility)</b></li>   <li>▪ <b>Other</b></li> </ul>	
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>	
<b>Total Example Cost</b>	
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	
Copayments	
Coinsurance	
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Peg would pay is</b>	

<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)	
<ul style="list-style-type: none"> <li>▪ <b>The <u>plan's</u> overall <u>deductible</u></b></li> <li>▪ <b><u>Specialist</u></b></li>   <li>▪ <b>Hospital (facility)</b></li>   <li>▪ <b>Other</b></li> </ul>	
<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>	
<b>Total Example Cost</b>	
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	
Copayments	
Coinsurance	
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Joe would pay is</b>	

<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)	
<ul style="list-style-type: none"> <li>▪ <b>The <u>plan's</u> overall <u>deductible</u></b></li> <li>▪ <b><u>Specialist</u></b></li>   <li>▪ <b>Hospital (facility)</b></li>   <li>▪ <b>Other</b></li> </ul>	
<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	
Copayments	
Coinsurance	
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Mia would pay is</b>	

The plan would be responsible for the other costs of these EXAMPLE covered services.