Medicaid/
Healthy Michigan Plan
Member Handbook
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Nondiscrimination Notice

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, gender identification, sex or sexual orientation.

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.

- 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, 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.
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: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-826-2862 (TTY: 711).

Chinese Mandarin: 注意: 如果您使用中文普通话, 我们可为您提供免费语言援助服务。请致电 (800) 826-2862 (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)。

Chinese Traditional: 注意: 如果您說中文普通话, 您可以免費獲得語言援助服務。請致電 (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).


Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে বিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। কোন করুন ১ (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).


At Total Health Care, We Care About Your Health

HERE’S WHAT WE WANT FOR YOU
Total Health Care is committed to excellence in health care delivery in the State of Michigan. We ensure that our members have access to and receive high quality health care and preventive services that promote wellness and improve health status within the community. Total Health Care maintains a standard of totally available and totally helpful.

YOUR GUIDE TO TOTAL HEALTH CARE
Your Member Handbook will serve as a quick and easy guide to help you understand your benefits. Please use the handbook as a reference; it does not modify or take the place of your Certificate of Coverage. For quick and easy Member Tips, refer to page 4 of your Member Handbook.

GET THE MOST OUT OF YOUR HEALTH CARE
It is important to have a good relationship with your Primary Care Physician (PCP). Your PCP is your personal doctor and is a valuable resource when you have questions about your health. We encourage you to schedule a check-up as soon as possible; this will give your PCP a chance to assess your health.

If you decide a different PCP is better for you, and would like to change, call us by the end of the month. This ensures you will be able to see your new PCP effective the 1st of the following month.

IF YOU HAVE QUESTIONS
Our Customer Service Department is available to answer questions about benefits or other services. You can also access helpful information about your plan by visiting our online member portal at www.THCmi.com.

INTERPRETER SERVICES
Total Health Care can arrange for an interpreter to help you speak with us or your doctor in any language. Interpreter services and translated materials are free for our members. Call Customer Service at (313) 871-2000 or (800)826-2862, Monday–Friday, 8:00 a.m. to 5:00 p.m. for help getting an interpreter or to ask for our materials in another language.

HEARING AND VISION IMPAIRMENT
Total Health Care can help members with disabilities, such as visual and hearing problems or language barriers.

Language Help: (800) 826-2862, TDD/TTY Line: 711

Thank you for allowing us to become your partner in health. We look forward to serving you and meeting your health care needs.
Managed Care Definitions

1. Appeal
   An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:
   • Denies your request for:
     – A healthcare service
     – A supply or item
     – A prescription drug that you think you should be able to get
   • Reduces, limits or denies coverage of:
     – A healthcare service
     – A supply or item
     – A prescription drug you already got
   • Your plan stops providing or paying for all or part of:
     – A service
     – A supply or item
     – A prescription drug you think you still need
   • Does not provide timely health services

2. Copayment
   An amount you are required to pay as your share of the cost for a medical service or supply. This may include:
   • A doctor’s visit
   • Hospital outpatient visit
   • Prescription drug
   A copayment is usually a set amount. You might pay $2 or $4 for a doctor’s visit or prescription drug.

3. Durable Medical Equipment
   Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:
   • Oxygen equipment
   • Wheelchairs
   • Crutches
   • Blood testing strips for diabetics

4. Emergency Medical Condition
   An illness, injury or condition so serious that you would seek care right away to avoid harm.

5. Emergency Medical Transportation
   Ambulance services for an emergency medical condition.

6. Emergency Room Care
   Care given for a medical emergency when you think that your health is in danger.

7. Emergency Services
   Review of an emergency medical condition and treatment to keep the condition from getting worse.
8. Excluded Services
Health care services that your plan doesn’t pay for or cover.

9. Grievance
A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you’re unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

10. Habilitation Services and Devices
Health care services that help a person keep, learn or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:
- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

11. Health Insurance
Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

12. Home Health Care
Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

13. Hospice Services
Hospice is a special way of caring for people who are terminally ill and provide support to the person’s family.

14. Hospitalization
Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

15. Hospital outpatient-care
Care in a hospital that usually does not need an overnight stay.

16. Medicaid Health Plan
A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

17. Medically Necessary
Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:
- An illness
- Injury
- Condition
- Disease or
- Symptom
18. Network
Health care providers contracted by your plan to provide health services. This includes:
- Doctors
- Hospitals
- Pharmacies

19. Network Provider/Participating Provider
A healthcare provider that has a contract with the plan as a provider of care.

20. Non-participating Provider/Out-of-Network Provider
A healthcare provider that does not have a contract with the Medicaid health plan as a provider of care.

21. Physician Services
Healthcare services provided by a person licensed under state law to practice medicine.

22. Plan
A plan that offers health care services to members that pay a premium.

23. Preauthorization
Approval from a plan that is required before the plan pays for certain:
- Services
- Medical equipment or
- Prescriptions
This is also called prior authorization, prior approval or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

24. Premium
The amount paid for health care benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

25. Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

26. Prescription Drugs
Drugs and medications that require a prescription by law by a licensed Provider.

27. Primary Care Provider
A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician.

Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

28. Provider
A person, place or group that’s licensed to provide health care like doctors, nurses and hospitals.

29. Rehabilitation Services and Devices
Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:
- Physical and occupational therapy
• Speech-language pathology
• Psychiatric rehabilitation services

30. Skilled Nursing Care
Services in your own home or in a nursing home provided by trained:
• Nurses
• Technicians or,
• Therapists

31. Specialist
A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

32. Urgent Care
Care for an illness, injury or condition bad enough to seek care right away but not bad enough that it needs emergency room care.
## New Member Tips

**As a New Member:**

1. Please review your Total Health Care ID card(s) to make sure your name and your Primary Care Physician’s (PCP) information are correct.
2. You should read all member materials.
3. You are encouraged to call and schedule an appointment with your PCP within 60 days of enrollment with Total Health Care. When making the appointment, have your Total Health Care ID card in front of you.
4. Healthy Michigan Plan members must make an appointment with your PCP within 60 days of enrollment. A Health Risk assessment must be completed prior to your first appointment with your PCP.
5. Be sure to keep your Member Handbook. Your member handbook is available in paper form at no charge to you. If you request a paper handbook it will be processed within 5 business days. An electronic version of the handbook is available online on our website at www.THCmi.com. IMPORTANT – Your PCP will coordinate all your health care needs except as otherwise stated in this handbook.
6. Total Health Care will notify you within 30 days on any significant changes in benefits, our contact number, need for prior authorization and copay changes for Healthy Michigan enrollees.

## Important Telephone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Care</td>
<td>(800) 826-2862 or (313) 871-2000</td>
</tr>
<tr>
<td>Claims</td>
<td>(800) 826-2862 or (313) 871-2000</td>
</tr>
<tr>
<td>Children’s Special Health Care Services Program (CSHCS) Case Management</td>
<td>(800) 826-2862 or (313) 871-2000</td>
</tr>
<tr>
<td>Emergency</td>
<td>911</td>
</tr>
<tr>
<td>Fair Hearing</td>
<td>(877) 833-0870</td>
</tr>
<tr>
<td>Grievance Coordinator</td>
<td>(313) 871-6583 or (800) 826-2862</td>
</tr>
<tr>
<td>Health Education and Wellness Coordinator</td>
<td>(313) 293-6441 or (800) 826-2862</td>
</tr>
<tr>
<td>Hearing Impaired</td>
<td>711</td>
</tr>
<tr>
<td>Language Needs – Customer Service Department</td>
<td>(800) 826-2862 or (313) 871-2000</td>
</tr>
<tr>
<td>Customer Service Department</td>
<td>(313) 871-2000 or (800) 826-2862</td>
</tr>
<tr>
<td>Michigan Enrolls</td>
<td>(888) 367-6557</td>
</tr>
<tr>
<td>Poison Control Center</td>
<td>(313) 745-5711</td>
</tr>
<tr>
<td>State of Michigan Hotline</td>
<td>(800) 642-3195</td>
</tr>
<tr>
<td>Transportation</td>
<td>(800) 826-2862, ext. 3608</td>
</tr>
<tr>
<td>Nurse Advice Line</td>
<td>(800) 826-2862, ext. 4357 (HELP)</td>
</tr>
<tr>
<td>Case and Medical Management</td>
<td>(800) 826-2862, ext. 3355</td>
</tr>
</tbody>
</table>
General Information
If you are a new member, your coverage begins on your effective date. This is the date you can begin using your Total Health Care benefits.

Co-Payments
Total Health Care will pay for all covered services. There are no co-payments (For Healthy Michigan Plan co-payment refer to page 5).

Your Member ID Card
Every enrolled member of your family has their own ID card. Always carry your card with you. If you do not receive a card, call our Customer Service Department. Only members of Total Health Care can use our services. If your card is lost or stolen, let us know immediately at (313) 871-2000 or toll-free at (800) 826-2862.

How To Make an Appointment
When you join the Plan, you must select a PCP. For a list of doctors and specialists in your area visit our website at THCmi.com or find a doctor at http://totalhealthcare.prismisp.com/. You are encouraged to schedule your first appointment within 60 days of enrollment with Total Health Care (Healthy Michigan Plan members must schedule an appointment within the first 60 days of enrollment). During your first appointment, your PCP will set up your health record. You can ask your doctor’s office for their office hours, how to get there, and what to do in case of a medical emergency.

Your PCP’s phone number is listed on your Total Health Care ID card. It is important to have your Total Health Care ID card available when you are making an appointment.

You can find information on doctors, pharmacies, and vision care in the Total Health Care Provider Directory or online at www.THCmi.com.

Our Customer Service Department can also help at (313) 871-2000 or toll-free at (800) 826-2862.

How To Change Or Cancel an Appointment
Remember to call your doctor’s office if you will be late or are not able to keep your appointment. The doctor’s office will change your appointment time or day.

How To Choose Your PCP
We want you to choose a PCP who is right for you. You may want to choose a PCP based on location, hospital system, sex, or language spoken. Your PCP will handle all of your health care needs, except as otherwise stated in this handbook. Our website lists network doctors with their addresses and phone numbers at THCmi.com/find a doctor or http://totalhealthcare.prismisp.com/.

The type of PCP you choose may be:

- Family Practice – a doctor who cares for adults and children
- Internal Medicine – a doctor who cares for adults
How To Change Your PCP
A good relationship with your PCP is important for the best care. If you decide a different PCP is better for you, you have the option to choose a different PCP. To change your PCP call our Customer Service Department toll free at (800) 826-2862 or you can change your PCP online in our member portal www.THCmi.com. When you change your PCP, you will be sent a new ID card.

What To Do When Your Family Size Changes
You should call the Customer Service Department and the Michigan Department of Health and Human Services (MDHHS) office if you have had any change in your family size. Examples of change are: birth of a child, adoption of a child, and death. It is important that Total Health Care knows the family members who should be part of the health plan.

How To Get Help and Information
Total Health Care is here to answer your questions. Call our Customer Service Department 24 hours a day, 7 days a week, at (313) 871-2000 or toll-free at (800) 826-2862. The best times to call are Monday–Friday, 8:00 a.m. to 5:00 p.m. Our online member portal at www.THCmi.com is available for your convenience 24 hours a day, 7 days a week. It contains helpful information and tools to help you manage your health.

We Can Assist With:
- General information
- Replacing a Total Health Care ID card
- Change of address or telephone number
- Changing doctors
- Claims information
- Wellness programs
- Benefit information
- PCP’s address and telephone information
- Children’s Special Health Care Services
- Enrollment or dis-enrollment questions
- Grievance/appeals and complaints
- An urgent medical problem
- Emergency or medically necessary transportation needs
- Questions regarding whether Total Health Care has special payments with its doctors that might change referrals and other services that you may need
- Obtaining written materials in alternative formats
- Translation services

How to Get Referrals for Specialty Care
If you think you need to see a specialist, visit your PCP. Together, you can decide what care is best. You do not need to see your PCP for a referral to obtain routine services from your OB/GYN or Pediatrician. Most specialists do not require a referral from your PCP as long as the specialist is in the Total Health Care network. Use the Find a Doctor search online at
www.THCre.com to be sure the doctor is in our network. You can search by name, specialty, or city. You can also call our Customer Service Department for help finding doctors in your area or if you have a question on which specialists require a referral from your PCP.

Your PCP and specialist will work together to manage your care and make sure all procedures are followed. This includes needed referrals or authorizations for service.

You can also choose a specialist to be your PCP if you have a chronic health condition. In certain cases, it may be better for a specialty doctor to be in charge of all your health care needs. Call the Case Management Department at (313) 871-2000 or toll-free at (800) 826-2862, if you think you need a specialist as your PCP.

The Healthy Michigan Plan
The Healthy Michigan Plan is a health care program through the Michigan Department of Health and Human Services (MDHHS).

The Healthy Michigan Plan covers enrollees who are:
- Ages 19-64
- Not currently eligible for Medicaid
- Not in or qualified for Medicare
- Not pregnant when applying for the Healthy Michigan Plan
- Earning up to 133% of the Federal Poverty Level (FPL)
- Are residents of the State of Michigan

Healthy Michigan Plan Additional Benefits
- Dental Services will be provided through Healthy Michigan Dental. For help finding a dentist call (844) MY-TOTAL (698-6825)
- Habilitative Services

Healthy Michigan Plan Contributions
The Healthy Michigan plan requires those with incomes between 100% and 133% of the federal poverty level must contribute 2% of income annually for cost sharing purposes. You can reduce your annual contribution and co-payments by participating in healthy behavior activities which may include completing the annual health risk assessment, and changing unhealthy activities. Cost sharing cannot exceed 5% of your income.

Healthy Michigan Plan Co-Payments
Co-payments will be made to Total Health Care through a special health care account called the MI Health Account. Co-payments will not be collected for the first six months after enrollment, but will be paid through your MI Health Account at a later time.
Healthy Michigan Plan

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>Co-pay income less than or equal to 100% FPL</th>
<th>Co-pay Income more than 100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (including Free-Standing Urgent Care Centers)</td>
<td>$2</td>
<td>$4</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic Visit</td>
<td>$1</td>
<td>$4</td>
</tr>
<tr>
<td>Emergency Room Visit for Non-Emergency Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Co-payment ONLY applies to non-emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There is no co-payment for true emergency services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Stay (with the exception of emergency admissions)</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$1 preferred, $3 non-preferred</td>
<td>$4 preferred, $8 non-preferred</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>$1</td>
<td>$3</td>
</tr>
<tr>
<td>Dental Visits</td>
<td>$3</td>
<td>$4</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3/aid</td>
<td>$3/aid</td>
</tr>
<tr>
<td>Podiatric Visits</td>
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<td>$4</td>
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<tr>
<td>Vision Visits</td>
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What To Do If You Get a Bill
To reduce the chance of getting a bill, always show your Total Health Care ID card to your provider. If you receive a bill for a covered service, you may not be responsible for paying it. Send us a copy. Write your ID number and phone number on the bill. Mail the bill to:

Total Health Care, Inc.
Attention: Customer Service
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202

We will pay the hospital and doctors for all emergencies and other Total Health Care approved services. For us to pay, the services must be billed by a financial institution or entity with a United States address. If the address is not in the United States, you must pay the bill. Total Health Care will refund you for reasonable expenses or fees.

Getting Your Questions Answered About Your Doctor and Total Health Care
Before a doctor is accepted in the Total Health Care network, strict rules must be met. Our Customer Service Department can answer questions about a Total Health Care doctor, including:

• The professional qualifications of our doctors such as specialty, medical school attended, residency completed and board certification status.
• General information, including name, address phone numbers and identification of doctors who are accepting new members.

Incentives and Your Doctor
Total Health Care does not pay doctors or encourage them in any way to withhold or deny medical care or services. Your care is based on your health care benefits and medical needs. If you have any questions about this, call our Customer Service Department.
How to Change Your Health Plan
If you find that we are not the right plan for you, you have the right to change to a different health plan.

If you have enrolled with Total Health Care within the past 90 days:
- Call the State office at (888) 367-6557 (MICHIGAN ENROLLS) – they can help you choose a new plan
- You must keep seeing your Total Health Care doctor until you are enrolled in another health plan

If you have been enrolled with Total Health Care for more than 90 days:
- The State allows you to change health plans once a year, during the State’s open enrollment period – watch for the information from the State in the mail
- If you are changing health plans, you must keep seeing your Total Health Care doctor until you are enrolled in another health plan

You have the right to request a For Cause Dis-enrollment from Total Health Care at any time:
- When you cannot change health plans due to enrollment over the 90-day lock-in; or
- When the time frame guidelines for a medical exception have expired

Reasons to request dis-enrollment include:
- Lack of access to providers
- Necessary specialty services that are covered under Medicaid but are not covered by Total Health Care
- Concern with quality of care

Children’s Special Health Care Services (CSHCS) Program
CSHCS is a State of Michigan program that serves children, and some adults, with special health care needs. CSHCS covers more than 2,700 medical diagnoses.

Additional Benefits for Healthy Michigan Plan Enrollees with CSHCS
1. Help from your Local Health Department with:
   - Community resources – schools, community mental health, respite care, financial support, childcare, Early On, and the Women, Infants, and Children program (WIC)
   - Transitioning to adulthood

2. Help from the Family Center for Children and Youth with Special Health Care Needs:
   - CSHCS Family Phone Line – a toll-free phone number (800) 359-3722 available Monday–Friday, 8:00 a.m. to 5:00 p.m.
   - Parent-to-parent support network
   - Parent/Professional training programs
   - Financial help to go to conferences about CSHCS medical conditions and “Relatively Speaking,” a conference for siblings of children with special needs

3. Help from the Children’s Special Needs Fund (CSN):
The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. To see if you qualify for help from the CSN Fund, call (517) 241-7420.
Examples include:
- Wheelchair ramps
- Air conditioners
- Van lifts and tie downs
- Adaptive recreational equipment
- Electrical service upgrades for eligible equipment
- Therapeutic tricycles

MIChild Program
Total Health Care is part of Michigan’s MIChild program. MIChild members have Dental Benefits and cost sharing premiums. There are no copayments for MIChild.

MIChild Dental Benefits
All MIChild eligible children ages 0 through 18 will receive dental services through Healthy Kids Dental program, administered by Delta Dental of Michigan. You may call Delta Dental of Michigan at (800) 482-8915 or our Customer Service Department to obtain a detailed screening and a referral to a dentist.

MIChild Cost-Sharing Requirements
Most Families enrolled in the MIChild program are required to pay a premium of $10 per family per month for MIChild coverage. MIChild will notify you if you will need to pay a premium.

If you have questions on MIChild coverage, call our Customer Service Department or the MIChild Program at (800) 988-6300 or visit www.michigan.gov/michild.

Benefits Monitoring Program (BMP)
BMP is a program that reviews the use of Medicaid services. We look at certain types of Medicaid services to assess appropriate use. We look to see if the services are needed for your medical condition. We also provide education on the correct way to use Medicaid services.

You may be placed in BMP if any of the following are not needed for your medical condition:
- Too many emergency department visits
- Filling too many prescriptions
- Seeking services from too many doctors
- Fraud

You will receive a letter if you are placed in the BMP and will be assigned to receive certain medications from your PCP and/or from a certain pharmacy. If you have any questions about BMP, call our Customer Service Department.

Disease and Case Management Programs
Total Health Care offers Disease Management and Case Management programs that can help you take care of yourself. Our nurses can help you manage chronic conditions, such as diabetes, high blood pressure, asthma, heart failure or COPD (emphysema). We can also help you with life situations that may impact your health, such as transportation, medications, or scheduling appointments. As part of our Case Management program, our community health workers may be able to assist you with other supportive services. These programs were created to keep you healthy and out of the hospital.

For more information about our Disease Management, Case Management and Community-Based Support Programs visit our website at THCmi.com; Health and Wellness tab, or call us at (800) 826-2862.
Medical Benefits

What is Covered by Total Health Care?

Every member of Total Health Care gets a Certificate of Coverage. Please review your Certificate of Coverage for detailed benefit information.

The following is a description of your benefits. All services must be medically necessary to be covered. Your doctor can help you get these services:

- Autism Screening
- Blood Lead Testing (for Members under 21)
- Certified Nurse Midwife Services
- Certified Pediatric and Family Nurse Practitioner Services
- Child and Adolescent Health Centers
- Children’s Multidisciplinary Specialty (CMDS) Clinics
- Chiropractic Services
- Dental Services for Medicaid pregnant women and up to three months after delivery
- Dental Services for Healthy Michigan Plan
- Durable Medical Equipment and Supplies
- Emergency Services
- End Stage Renal Disease (Hemodialysis)
- Family Planning Services
- Habilitative Services for Members under 21
- Health Education
- Hearing and Speech Services
- Hearing Aids
- Home Health Services
- Hospice Services
- Immunizations
- Inpatient and Outpatient Hospital Services
- Laboratory, X-ray and other Imaging Services
- Long-term Acute Hospital Services (LTACH)
- Maternal Infant Health Program (MIHP)
- Medically Necessary Weight Reduction Services
- Mental Health Care
- Out of State Emergency or Authorized Services
- Outreach for covered services, including Pregnancy and Well-Child Care
- Parenting and Birthing Classes
- Pharmacy Services
- Podiatry Services
- Practitioners’ Services
- Preventative Services required by the Patient Protection and Affordable Care Act
- Prosthetics and Orthotics
- Restorative or Rehabilitative Services (in a nursing facility) up to 45 days
- Therapies (Speech, Language, Physical, Occupational and therapies to support activities of daily living)
- Tobacco Cessation Treatment
- Transplant Services
- Transportation including Ambulance, other Emergency Medical Transportation, and for Medically Necessary Covered Services, including ambulance services to and from the nursing facility or enrollee’s homes
- Transportation for dental services for Medicaid pregnant women and HMP members
- Treatment for Sexually Transmitted Diseases (STD)
- Vision Services
- Well-Child Care/ EPSDT for Members under age 21

For help getting any of these services, call your PCP or our Customer Service Department.

What’s Not Covered by Total Health Care?

Some services are covered by Medicaid fee for service, not by Total Health Care. These services include substance abuse and some mental health services. For help getting any of the services that are not covered by Total Health Care, call your PCP or our Customer Service Department.
If you live in Wayne, Oakland or Macomb County and need a ride to these services, call Logisticare at (866) 569-1902. They are open Monday–Friday from 8:00 a.m. to 5:00 p.m.

What Services are Excluded?
There are certain services that are not covered by Total Health Care or the Healthy Michigan Plan. They are:

• Elective Abortions and Related Services
• Elective Cosmetic Surgery
• Experimental or Investigational Drugs, Procedures, or Equipment
• Services for Treatment of Infertility
• Personal Care or Home Help Services
• Restorative or Rehabilitative Services (in a nursing facility), after 45 days
• Services provided to persons with Developmental Disabilities provided by other agencies such as Outpatient Mental Health Providers or Intermediate School Districts
• Services provided by a School District and billed through the Intermediate School District
• Substance Abuse Services, including some drugs
• Transportation for services not covered by Total Health Care
• Traumatic Brain Injury Program Services

Prescription Drug Benefits – Frequently Asked Questions

What Drugs are Covered?
Total Health Care approves a list of drugs that are covered for use. This list is called Michigan’s Common Drug Formulary. The list includes prescription drugs and over-the-counter products (such as aspirin, insulin needles and test strips). Members can obtain a copy of Michigan’s Common Drug Formulary by calling our Customer Service Department at (313) 871-2000 or toll-free at (800) 826-2862, or you can find it on our website at www.THCmi.com.

For a drug to be covered by Total Health Care, the drug must be:

• On the formulary or approved by Total Health Care
• Prescribed by a Total Health Care doctor
• Filled by a Total Health Care pharmacy

What Drugs are Not Covered?

• Drugs for cosmetic use
• Fertility drugs
• Drugs used for erectile dysfunction
• Medicare Part D drugs are excluded for Medicare/Medicaid dual eligibles
Special Coverage Information

Special coverage and payment policies apply to certain types of services and providers, including the following:

**Access to Continued Service Upon Transition to Total Health Care**
If you are a new member and are currently receiving treatment from an out-of-network provider please call our Case Management department at (800) 826-2862, extension 3355. One of our nurse case managers will work with you and your doctor to transition your medical information to a Total Health Care provider.

**Urgent Care Centers**
Urgent Care Centers can save time by treating you quickly with no appointment. Urgent Care Centers are available to treat minor injuries and can be used when you cannot be seen by your PCP.

Examples of conditions that After Hours Care Centers can treat are:
- Sore throat
- Earache
- Back pain
- Minor injury
- Cuts and minor wounds
- Headache
- Frequent urination
- Minor burns

If you're unsure if the condition can be treated by an Urgent Care Center, call your doctor. If your doctor's office is closed, Total Health Care has a Nurse Advice Line that is here to give you around
the clock medical information and advice. A nurse can tell you if an appointment with your doctor, after hours care, or the emergency room is the better place for treatment. To speak with a nurse at any time, call (800) 826-2862, ext. 4357 (HELP).

Emergency Services
You are always covered in case of a medical emergency. If you have a life threatening emergency, go quickly to the nearest emergency room or call 9-1-1.

Some examples of life-threatening emergencies are:

- A serious accident
- Seizure
- Poisoning
- Bleeding you can’t stop
- Pregnancy with vaginal bleeding
- Loss of consciousness
- Heart attack
- Severe shortness of breath
- Serious burns
- Drug overdose
- Head trauma
- Stroke

If you’re not sure the condition needs emergency care, call your doctor. If your doctor’s office is closed, call our Nurse Advice Line at (800) 826-2862, ext. 4357 (HELP). Prior Authorization is not required for Emergency services. You have the right to use any hospital for emergency care.

Hospital Services
Admission to the hospital can happen in many ways. You may be treated in the emergency room (ER) but need more treatment; this can lead to a hospital stay. Other times, it can be for a planned admission for elective (non-emergency):

- surgery;
- tests; or
- special procedures

If you are admitted from the ER, the hospital must call Total Health Care for approval. If you are admitted to an out of network hospital, Total Health Care may move you to a network hospital if your medical condition is stable (not in an emergency crisis). If it is determined that you are stable to be transferred to a network hospital and you refuse, Total Health Care may not be responsible for payment. If you are scheduled for an elective admission, your PCP must call Total Health Care for prior approval 14 days before the admission.

Out of Service Area Care
If you are out of Total Health Care’s service area and have a medical emergency, go to the nearest hospital or medical center.

If you need care for non-life threatening services, call your PCP. Your PCP can give you medical advice. If your PCP is not available, you may call the Total Health Care Nurse Advice Line 24 hours a day/7 days a week at (800) 826-2862, ext. 4357 (HELP). A nurse can tell you if an appointment with your doctor, after hours care or the emergency room is the better place for help. To speak to a nurse at any time, call (800) 826-2862, ext. 4357 (HELP).

Routine medical care outside of the service area or out of network and out of state is not covered, unless approved by Total Health Care. To request approval, call our Customer Service Department.

You do not need approval from your PCP or Total Health Care for emergency or urgent care. Remember to:

- Show your member ID card
- Call your PCP for follow-up care
Other Benefits/Services

There are times when other services are needed. Your doctor or Total Health Care can arrange for these services. These services are described below:

**Abortions**
Total Health Care does not pay for abortions (or related services) to end a pregnancy unless the pregnancy was the result of rape, incest or when medically necessary to save the life of the mother. Treatment for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies are covered. If you have questions, call our Customer Service Department.

**Child and Adolescent Health Centers and Programs (CAHCP)**
Enrollees may choose to obtain covered services from a Child and Adolescent Health Centers and Programs (CAHCPs) provider without prior authorization.

**Children’s Multidisciplinary Specialty (CMDS) Clinics**
Enrollees may choose to obtain services from a Children’s Multidisciplinary Specialty Clinic without prior authorization from the Plan.

**Chiropractic Services**
Total Health Care covers up to 18 Chiropractic visits a year. For a referral, contact your PCP.

**Dental Services**
You can get dental screening and a referral to a dentist. This is an important part of health care. It is also important for your child to have a dental screening by 2 years of age. Your PCP can help you arrange this or call our Customer Service Department.

The Healthy Kids Dental program is offered statewide to those who get Medicaid and are ages 0 through 20 years. You will be enrolled automatically. The two Dental plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card from the dental plan. It will have the phone number for your plan. You can call your dental plan for help in finding a dentist.

**BCBSM**
bcbsm.com/healthy-kids-dental
Phone: 800-936-0935

**Delta Dental**
www.deltadentalmi.com
Phone: 1-866-696-7441

**Dental Services For Healthy Michigan Plan (HMP) and Medicaid Pregnant Women**
Healthy Michigan Plan covers basic dental care, including exams, cleanings, fillings and extractions. As an added benefit, THC provides our HMP members with some coverage for root canal, crowns and periodontal cleanings. Major dental services must be pre-approved and some services have certain limitations. In order for your dental services to be covered, you must go to a dentist that participates within Healthy Michigan Dental’s Provider Network. Your participating dentist will be able to tell you more about your dental coverage.
It is important that you visit your dentist every 6 months for regular cleanings to keep your teeth and gums healthy.

 Medicaid Pregnant women to receive dental services must:
   • Notify THC of pregnancy and due date by calling customer service at (800) 826-2862.
   • Members should also notify their caseworker of their pregnancy and due date.

 **Durable Medical Equipment (DME)**
 Sometimes you need supplies or special medical equipment called DME. Either your PCP or Total Health Care can arrange this for you. If you think you need special DME, call Binson’s Medical Equipment & Supplies at (888) 246-7667, or call your PCP for help. This equipment must be medically necessary to be a covered benefit.

 Diabetic supplies are to be filled through J&B Medical Supply. If you have any questions about our diabetic supply program, please contact J&B Medical Supply at (844) 236-7933.

 **Early and Periodic Screening, Diagnosis & Treatment (EPSDT) under age 21**
 EPSDT is a child health program of early and periodic screening, diagnosis and treatment, including preventive services for children and adolescents under age 21. Additionally, objective testing for developmental behavior, hearing, dental, vision and specialty services must be performed in accordance with the periodicity schedule included in Medicaid policy. Autism screening is a covered service.

 **Family Planning**
 Family planning is an important part of health care. Services included in family planning are:
   • Prescriptions and devices to prevent pregnancy, including Long-Acting Reversible Contraception (LARC)
   • Education in family planning
   • Diagnosis and treatment of sexually transmitted diseases (STDs)

 Total Health Care and your doctor can help you with family planning services, or you can choose a family planning agency. This can include another doctor, nurse practitioner, a family planning clinic, or your local health department. Family planning services do not require a referral.

 **Federally Qualified Health Centers**
 If there is a Federally Qualified Health Center in the county where you live, you may choose to get services from them. You do not need a referral from your PCP for these services and Total Health Care will pay for all costs.

 **Foreign Language Services**
 If you do not speak English, Total Health Care can help you get an interpreter for health services and/or provide written materials in your language.

 **Hearing Aids**
 Total Health Care covers hearing aids and supplies for all Healthy Michigan and Medicaid members. For help, call our Customer Service Department or the TDD/TTY line at 711.

 **Hearing Impaired Services**
 If you have a hearing problem, Total Health Care can get you a sign language interpreter during health care services. For help, call our Customer Service Department or the TDD/TTY line at 711.
Hospice Services
Hospice services give help to people with terminal illnesses. To get hospice benefits, call our Customer Service Department or the TDD/TTY line at 711.

Indian Health Service/Tribally-Operated Facility/Program/Urban Indian Clinic (I/T/U)
Native American members may see an I/T/U provider as their PCP without a referral or prior authorization.

Low-Vision Services
Total Health Care covers low-vision services for members. This includes low-vision eyeglasses, optical devices, and other related low-vision supplies and services. Contact lenses require a prior authorization.

Maternal Infant Health Program (MIHP)
Total Health Care has staff to help you get the services you need when you are pregnant. Please call our Customer Service Department and ask for the Maternal Infant Health Program. The program helps mothers and infants get the proper nutrition, support and transportation for health care. It also helps mothers understand the importance of getting prenatal care, well-child visits, and shots when they are needed. MIHP services include:

- Visits during and after your pregnancy
- Nurses who teach about pregnancy, labor and delivery and baby care
- Social workers
- Dietitians
- Parenting classes
- Referrals to local community services
- Referrals to local childbirth classes
- Transportation services

Mental Health Services
Good mental health is important for your overall health. Total Health Care provides short term treatment for mental or emotional needs. A referral from your PCP is not needed. If you think you need help or to find a provider, call (855) 377-2416 or (800) 826-2862, ext. 3606.

The local Community Mental Health (CMH) agency helps you get treatment for long term, severe mental conditions, or severe emotional disturbances for kids. CMH also provides for inpatient and intensive outpatient treatment. To find an agency near you, call our Customer Service Department.

New Technology
New treatments and new use for old treatments occur all the time. We have a committee, staffed by doctors, that reviews the information from the government, trials, and writings by other doctors to see if members could benefit from the use of the new technology. If it is found to be helpful for all members or some cases, it will be added to the benefits.

Other Breast Services Following Mastectomy
Total Health Care covers mastectomies, reconstructive breast surgery and post-mastectomy related services. Benefits include:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
• Prosthesis
• Treatment of physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient

**Pediatric Services**
Total Health Care has many pediatric doctors as part of its network. You may choose a pediatric doctor for your child as their PCP. You may take your child for routine services to a pediatric doctor in our network without a referral.

**Persons with Special Health Care Needs/Developmental Disabilities**
Total Health Care provides services for persons with special health care needs in the county where you live. We work with your PCP to coordinate the care you need. For more information, call your PCP or our Customer Service Department.

**Prenatal/Postnatal Services**
All pre/postnatal services must be received by a Total Health Care doctor. You can self-refer only within the network. OB care from a non-Total Health Care doctor is not an option unless:
- Given a prior-approval from Total Health Care, and
- Only for special circumstances

**Prepaid Inpatient Health Plans (PIHPs)**
Total Health Care works with Prepaid Inpatient Health Plans (PIHPs) to improve integration of behavioral and physical health and will assist members with referrals, care coordination, grievance and appeal resolution and for the continuity of care for members served by PIHPs.

**Preventative and Wellness Services and Chronic Disease Management**
Preventative care is a key factor in wellness. Your covered care includes:
- Yearly check-ups
- Immunizations (shots)
- Doctor visits
- Mammograms
- Health education
- Hearing check-ups (including hearing aid evaluation)
- Follow-up care

Some other things you should do to improve your health include:
- Eat healthy
- Exercise
- Get enough sleep
- Manage your stress
- Don’t smoke or use tobacco
- Don’t use drugs or drink alcohol
- Visit your doctor every year for your preventative care

Some things you should not do include:
- Eat foods high in fat, sugar and salt
- Live an inactive lifestyle
• Hold in your feelings or emotions if you’re feeling stressed or depressed
• Use drugs, alcohol or tobacco
• Forget to set up a yearly visit to your doctor

If you are under age 21, these services are covered through Early, Periodic Screening, Diagnostic and Treatment (EPSDT).

**Restorative Health Services**
Total Health Care covers restorative or rehabilitation services, in a nursing care facility up to forty-five (45) days, and in a place other than a nursing facility as long as it is medically necessary.

**Rural Health Centers**
You have the right to receive services from Rural Health Center services. You do not need a referral from your PCP for these services and Total Health Care will pay for all costs.

**Second Opinion**
Total Health Care provides coverage for a second opinion from either a participating provider or arranges for the second opinion outside the network.

**Substance Abuse Services**
Substance abuse involves the use of alcohol or drugs and might make home, school, or work hard. Total Health Care provides help with this problem. If you have need of substance abuse help or need help to figure out if someone you know has a problem, call your PCP or our Customer Service Department.

**Transplant Services**
Total Health Care covers transplant surgery and related care. The Case Management Department will help you coordinate the transplant. If you are a candidate, call the Case Management Department at (800) 826-2862 ext. 3355.

**Transportation**
Total Health Care will provide a ride or gas reimbursement when you need help getting medical services. We will provide transportation if:

• You do not have a way to get medical items, treatment, prescriptions, or services that are covered by Total Health Care.

If you participate in the Maternal Infant Health Program (MIHP) your transportation benefits include the following:

• WIC appointments
• Substance abuse treatment
• Childbirth education or Breastfeeding classes
• Department of Health and Human Services (DHHS)

(Ensure you identify that you participate in MIHP when calling to schedule a ride) Total Health Care does not issue bus passes to pregnant members.

You should ask for transportation at least three (3) business days before your appointment. Call the Transportation Line at (800) 826-2862, ext. 3608 for assistance. If you need emergency transportation, call 9-1-1.
Vision Care Services
Routine eye exams and glasses are covered. Vision care does not require a referral. To find a vision care provider, call our Customer Service Department, or refer to the Provider Directory at www.THCmi.com.

Well-Woman Services
It is important to have a well-woman exam each year. Your PCP can help arrange this care for you or you can choose a specialist from the Total Health Care network. Routine well-woman care, provided by a network women's health specialist (OB/GYN), does not require a referral.

WIC Services
WIC stands for Woman, Infants, and Children. It is a free food and nutrition program for low-income people in Michigan who are at health risk due to inadequate nutrition. Your PCP or Total Health Care can help you find these services. If you think you qualify for WIC, call your local WIC office agency.
Learn About Health Education and Wellness Programs

Total Health Care wants to keep you healthy. As a member of Total Health Care we can help direct you to programs that help improve your health. For information about the programs listed below, call the Health Education and Wellness Coordinator at (313) 293-6441 or (800) 826-2862.

Learn About Childhood Immunizations (Shots) & Well-Child Checkups
It is important to get all required immunizations (shots) for your child to help keep him or her healthy. Your doctor will give all immunizations (shots) and well-child care check-ups for children and young adults under the age of 21. Call your doctor to make an office visit today or visit your local health department.

Learn About Your Pregnancy
Good health during pregnancy is important. If you become pregnant, or think you might be pregnant, call your PCP right away. Early and regular visits to your doctor can improve your chances of having a healthy baby. Your PCP can help you by caring for you directly, or by helping you find a specialist for care. You may also choose a specialist in our network. Our goal is to have both a healthy mom and baby.

Learn How to Quit Smoking
If you are ready to quit smoking, we can help. Total Health Care offers a smoking cessation program. To sign up, call (800) 784-8669.

Learn How to Control Your Weight
Total Health Care offers a weight loss program through Weight Watchers. We want you to make good food choices. We can help you decide what you must do to control your weight. Talk to your doctor about a referral to Total Health Care's weight loss program.

Learn About Asthma
Total Health Care has a program to help members with asthma. If you have asthma and need help to keep it controlled, we can teach you the do’s and don’ts to keep you healthy.

Learn About Diabetes
If you have diabetes, we have services to help you. Total Health Care’s nurses can help you get the diabetic drugs and supplies you need. They can also enroll you in classes that teach you how to control your diabetes with drugs, diet and exercise.

Learn About Heart Disease
If you have high blood pressure, diabetes, or high cholesterol, we can help you to learn how to lower your risk of heart disease. Ask about our Healthy-At-Heart Program.

Learn About High Blood Pressure
What you don’t know about high blood pressure can be harmful to your health. If not treated, high blood pressure can lead to many problems such as heart attack, stroke and kidney disease. Ask about our Healthy-At-Heart Program.
Know Your Member Rights and Responsibilities

- To ask for and be sent information about
  - Total Health Care
  - Our services
  - Our providers
  - Member rights and responsibilities
  - Our structure and operation
  - Our provider incentive programs and arrangements, including those that cover referral services that place the physician at significant financial risk (more than 25%) other types of incentive arrangements, and whether stop-loss coverage is provided. (We may give providers incentives to help make sure you get the care you need when you need it)
  - Your medical records
  - Changing or correcting your medical records
- To receive Federally Qualified Health Center (FQHC) services and Rural Health Clinic (RHC) services.
- To make recommendations regarding Total Health Care’s member rights and responsibilities policy
- To be treated with respect and with due consideration for his or her dignity and privacy
- To receive Culturally and Linguistically Appropriate Services (CLAS)
- To have privacy and confidentiality while you receive care
- To take part with your doctors in decision-making about your health care, including the right to refuse treatment
- To talk openly about your treatment options regardless of cost or benefit coverage – you have a right to get these explained to you in words that you understand
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To be free to exercise your rights without adversely affecting the way Total Health Care, our providers, or the State treat you
- To be free from other discriminations prohibited by State and Federal regulations
- To receive health care services consistent with your contract, State and Federal regulations
- To voice your complaints or grievance/appeals about Total Health Care or the care provided
- To request and receive a copy of your medical records, and request those be amended or corrected
- Receive information on available treatment options and alternatives presented in a manner appropriate to your condition and ability to understand

Total Health Care’s staff and providers will comply with all regulations concerning your rights.

You have the responsibility...

- To receive all your health care services through Total Health Care
- To understand your health care benefits
- To provide Total Health Care and its providers with the information needed to care for you
- To help your doctor decide what treatment will work best for you
- To follow the plans and instructions for care that you have agreed to with your doctor
• To respect the rights of other patients, doctors, and staff of Total Health Care
• To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

How to Voice a Complaint

If you have a problem or complaint, our Customer Service Department can help. The department is available Monday–Friday, 8:00 a.m. to 5:00 p.m. at (313) 871-2000 or (800) 826-2862.

Customer Service will try to solve your issues right away. Issues that cannot be solved right away are generally resolved within twenty-four (24) hours. If we are unable to solve your issue within twenty-four (24) hours or you do not agree with the solution, we will explain your rights. You have the right to file a grievance. At your request, the Customer Service representative will mail you a grievance form. If you need help writing the grievance, we can help you.

When filing a grievance, another person can act as your authorized representative. The person may be a family member, state agency representative, friend, or doctor. If you decide to use an authorized representative, you must send written consent to Total Health Care authorizing the person to act on your behalf.

Grievance

We will contact you by mail within two (2) business days to tell you that the Grievance Coordinator has received your grievance. If you do not agree with the resolution, you or your authorized representative may file a grievance/appeal by mail, email, or fax. You can also call (313) 871-2000 or (800) 826-2862 to file a grievance/appeal. The grievance/appeal information is included with your resolution letter.

How to Voice a Grievance/Appeal

Grievance/Appeal

A grievance/appeal is the procedure used when a grievance is not solved to your liking under the grievance process. Appeals can be due to:

• An administrative grievance/appeal may be due to a denial of payment to the provider.
  An administrative grievance/appeal may be due to a lack of authorization or the provider being out of THC’s network.
• An adverse determination means your health care services have been reviewed and denied, reduced or terminated; or an untimely response to a request

When filing a grievance/appeal:

• You or your authorized representative have 60 days from the date of the adverse determination letter to file a grievance/appeal
• You must give written consent for an authorized representative to represent you
• The consent must be sent with the grievance/appeal
At your request, we can help you file a grievance/appeal. You have the right to:

- Have your benefits continue pending resolution of the grievance/appeal
- Authorize someone to act as your authorized representative in the grievance/appeal process
- Send additional documentation with the grievance/appeal

At your request, we can arrange a meeting with the Appeal Review Committee:

- You can discuss your grievance/appeal with the committee
- You or your authorized representative can attend the meeting in person or by telephone
- A person not involved in the first decision will review your grievance/appeal
- No one who reports to the person involved in the initial decision can review your grievance/appeal
- The person who reviews your grievance/appeal will be of a similar specialty

When the grievance/appeal is received:

- You will get a letter of receipt of the appeal in 2 business days
- The 60 day determination/notification timeframe for a grievance begins on the date the grievance and authorized representative form (if applicable) are received.
- If the decision upholds the denial, an external appeal can be filed
- The final letter tells you of your external appeal rights and how to file the appeal

**Expedited Grievance/Appeal**

Sometimes, waiting may increase the risk of harm to your health or life. A grievance/appeal is expedited (quickly) when:

- A doctor tells us verbally or in writing that waiting 60 days will cause you to have severe pain or put your life at risk
- The doctor knows about your medical condition and can support the claim

When filing an expedited grievance/appeal:

- We will not punish a doctor who asks for or supports an expedited grievance/appeal
- The grievance/appeal must be received within 10 days of the denial
- After filing an expedited internal grievance/appeal, you can file an appeal to request an expedited external review with the Department of Insurance and Financial Services (DIFS)

Decisions about an expedited grievance/appeal:

- Will be made no later than 72 hours after receipt, and
- We will notify you of the decision by phone
- We will mail the decision to you within 2 business days
- You can request more time, moving the expedited grievance/appeal to a 30-day grievance/appeal

If the denial is upheld, you will get the reasons for the final denial. If you ask, you can have access to and copies of all papers related to your grievance/appeal. The notification letter will include:

- The benefit provision
- Guideline
• Protocol, or
• Other criteria used

External Appeal Rights
• You or your authorized representative have the right to ask for an Administrative Fair Hearing
• After you get your first denial letter, you have 120 days to ask for the hearing
• If you are getting benefits and ask for a hearing, there will be no action taken against you
• You can request a Fair Hearing after you receive notice that your Adverse Benefit Determination was upheld
• Your request for an Administrative Fair Hearing must be in writing
• An Administrative Fair Hearing request form will be sent with your denial letter
• The form must be signed by you or an authorized representative

IMPORTANT:
• An authorized representative must have your written consent to represent you
• The authorized representative can ask for a hearing for you
• The authorized representative can represent you at the Hearing
• The Hearing may be delayed, dismissed, or denied if you do not give written proof to the Michigan Department of Health and Human Services that you approved this person to act on your behalf
• You can use a letter or court order naming this person as a guardian or conservator
• Written permission is not needed if the person is your spouse or attorney

The Administrative Fair Hearing starts an appeal directly to the State of Michigan Department of Health and Human Services.

If you need help filling out the form, call Total Health Care at (800) 826-2862. If you have questions about the hearing process, call the State Office of Administrative Hearings and Rules at (877) 833-0870. Mail the form to:

Michigan Administrative Hearing System
for the Department Health and Human Services
P.O. Box 30763
Lansing, Michigan 48909-7695
EXTERNAL REVIEW DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES (DIFS):

- You or your authorized representative also have the right to ask for an external review from DIFS
- The request can be made after we tell you of the final decision
- Notification of the final decision completes our internal appeal process
- You or your representative must file the DIFS, Health Care-Request for External Review Form to get an external review
- A copy of the form will be sent with the final decision letter
- You can also call DIFS at (877) 999-6442 to have a form sent to you
- The form should be filed no later than 60 days after you get the final decision letter

When appropriate, DIFS gets the advice of an independent review organization. The organization is not part of Total Health Care. The organization reviews the grievance/appeal as stated in the Patients Right to Independent Review Act.

To ask questions about the external review process, call our Grievance Coordinator at (313) 871-2000 or (800) 826-2862. To request an independent review write to:

Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220, Lansing, Michigan 48909-7720

Courier/delivery:
530 W. Allegan Street, 7th floor, Lansing, MI 48933

Phone number: (877) 999-6442
Fax number: (517) 284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Notice of Privacy Practices – Total Health Care, Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Total Health Care, Inc. provides your health care benefits. We are required by law to maintain the privacy of your health information and to give you this notice of our legal duty and how we protect the privacy of your written, spoken and electronic health information. We are generally required to notify you if your health information is not secured and is used or released in a way that is not permitted by this notice or privacy laws. We will follow the requirements of this notice while it is in effect. This notice is effective September 23, 2013, and will remain in effect until we change it.

How We May Use and Release Your Health Information Without Your Permission

Only people who have both a need and a legal right may see your health information. Unless you give us written permission, we will only use and release your health information for the following purposes:
• To You or Your Personal Representative: We may release your health information to you or your personal representative (someone who has the legal right to act for you).

• For Treatment: We may use and release your health information to help you get health care. For example, we may notify your doctor about care you get in an emergency room.

• For Payment: We may use and release your health information so that your health care is correctly paid. For example, we may ask an emergency room for details about your health care before we pay the bill.

• For Health Care Operations: We may use and release your health information for our business operations. For example, we may use your information to review the quality of care you get or to talk to you about your health benefits.

• To Others Involved in Your Care: Unless you tell us not to, we may release your health information to a member of your family, a close friend, or any other person you request, if they are involved in your health care or payment for your health care.

• To Business Associates: We may release your health information to the companies we hire to help us in our business. Before these companies can get your information, they must agree in writing that they will follow our privacy rules.

• To Group Health Plans and Plan Sponsors: If you participate in an employee benefit plan that we insure, we may share certain health information with the employer that sponsors the plan under certain conditions required by law.

• Other Permitted Uses and Releases of Your Information: Although certain rules apply, we may use or release your health information as required by law; for public health activities; to a health oversight agency for activities authorized by law, such as inspections of our offices by the government; to a governmental authority if we reasonably believe that you have been a victim of abuse, neglect or domestic violence; as required by the Food and Drug Administration; in the course of judicial or administrative proceedings (for example, in response to an order of a court); in response to certain law enforcement requests; to coroners, medical examiners, and funeral directors; for organ, eye or tissue donation purposes; for workers’ compensation purposes; for special government functions, including national security and intelligence activities; and to avert a serious and immediate threat to the health or safety of a person or the public. We may disclose your health information to researchers in limited circumstances, if the researchers use privacy protections required by law. We must also release your information when required by the Michigan Department of Health and Human Services to investigate our compliance with the privacy laws.

• Health Related Benefits: We may use or release your health information to send you our newsletters or to tell you more about the benefits we offer.

• Written Permission: We may use your information for other purposes not described in this notice if you give us permission in writing. We generally need your permission to use or release your health information if it relates to psychotherapy notes, relates to marketing, or
relates to the sale of your health information. You have the right to change your mind and revoke your written permission. You must revoke your written permission in writing. We cannot take back any uses or releases made before you revoke your permission.

If we use or release your health information for underwriting purposes, we are prohibited from using or releasing your health information that is genetic information for underwriting purposes.

Generally, federal privacy laws regulate how we may use and release your health information. In some circumstances state law also regulates how we may use and release your health information. In such situations, we will comply with the law that is most protective of your health information and/or gives you additional rights.

**Your Rights**

You have the following rights regarding your health information:

Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your records upon written request. You may be charged a fee for the cost of copying your records. If we deny your request, you may ask to have our decision reviewed.

Right to Amend: Upon written request, you may ask us to change your records if you feel that the record is incorrect or incomplete. We may deny your request for certain reasons, but we must give you a written reason for our denial.

Right to a List of Releases: Upon written request, you have the right to receive a list of releases of your health information made by us during the six year period before the request. This list will not include information that was released for treatment, payment or health care operations, or as permitted as described above. This list will not include information provided directly to you or your family, or information that was released based upon your written permission.

Right to Request Restrictions on Our Use or Releases of Your Information: Upon written request, you have the right to ask for limits on how your health information is used or released. We are not required to agree to such requests.

Right to request counseling or referral for services not covered or reimbursable, because of an objection on moral or religious grounds. Upon written request, you have the right to ask for a review to approve counseling or referral services.

Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. Your request must be in writing. For example, you may ask us to send information to your work address instead of your home address.

How to Use Your Rights Under This Notice: If you want to use your rights under this notice, you may write to us at the address listed below. We will help you prepare your written request, if you wish.

**Changes to this Notice**

We reserve the right to change this notice. A revised notice will be effective for health information we already have about you as well as any information we may receive in the future. We are
required by law to comply with whatever notice is currently in effect. If the changes are important, the new notice will be mailed to you before it takes effect.

**Complaints**
Complaints to the Federal Government: If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:
U.S. Department of Health and Human Services, Office of Civil Rights, Centralized Case Management Operations, 200 Independence Avenue, Suite 515 F, HHH Building, S.W. Washington, D.C. 20201 Phone: (800) 368-1019, TTY: (800) 537-7697, or Email: ocr/mail@hhs.gov.

You will not be penalized for filing a complaint with the federal government.

Complaints and Communications to Us: If you want to exercise your rights under this notice, communicate with us about privacy issues, or if you wish to file a complaint about us, you can call or write to us at: 3011 W. Grand Blvd., Suite 1600, Detroit, MI 48202, or call (313) 871-2000 or (800) 826-2862.

You will not be penalized for filing a complaint.

**Copies of this Notice**
You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. Please call or write to us to request a copy.

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**Make Your Wishes Known**

You have the right to decide about Advanced Directives and medical treatments for yourself. Advance directives are legal documents that let your family, friends and doctors know about your end-of-life decisions. The advance directive is filled out before you become too sick to do so. Total Health Care wants you to decide about what treatments you want and about making a living will. Your new member material includes a Michigan Notice to Patients that outlines these rights in detail (see Appendix A: Advance Directives).

**Healthy Michigan Plan Members**
You may register your Advanced Directives with the Peace of Mind Registry. This is a free and voluntary registry that securely stores your advance directives and allows your doctors to access them if needed. Members can get advance directives and register them online by visiting www.mipeaceofmind.org. For more information on Advanced Directives, call the Customer Service Department at (313) 871-2000 or toll-free at (800) 826-2862. You may also call Peace of Mind Registry at (800) 482-4881.

You can also file a grievance if you do not think Total Health Care is following these rules. For more information, call the Customer Service Department at (313) 871-2000 or toll free at (800) 826-2862.
For complaints about how your provider followed your wishes, write or call:

Department of Licensing & Regulatory Affairs
BPL/Legal Affairs Division
P.O. Box 30670
Lansing MI 48909-8170
Phone: (517) 373-9196 or BPLhelp@michigan.gov

The Bureau of Professional Licensing (BPL) Complaint and Allegation website is www.michigan.gov/healthlicense (Click on Professional Licensing” and then, “file a complaint”).

For complaints about how your health plan followed your wishes, write or call: Department of Insurance and Financial Services toll-free at (877) 999-6442 or www.michigan.gov/difs

How You Can Help Stop Fraud and Abuse

Total Health Care has a fraud, waste, and abuse program (FWA). This program is to make sure health care money is used correctly. Healthcare FWA costs millions of dollars each year. This money should be spent on health care for people who need it. FWA violates State and federal law.

Here are some examples of fraud, waste and abuse.

• Changing information on a prescription, medical records, or referral forms
• Letting someone else use your Total Health Care card to get medical services
• Using transportation services to do something other than going for medical service
• Billing for services that weren’t done
• Billing for the same service more than once

Here are some examples of Abuse

• Using the emergency room for non-emergency care
• Going to more than one doctor to get the same prescription

Waste goes beyond fraud and abuse. Waste usually means poor management, inappropriate actions or inadequate oversight. It is not a violation of the law, but it takes money away from health care for people who need it.

Reporting FWA

If you have any information about FWA or think that someone may have used your ID card, please contact Total Health Care’s Fraud, Waste, and Abuse Monitoring Unit. You can report fraud, waste, and abuse anonymously without giving your name by writing or calling:

Total Health Care, Inc.
ATTN: Fraud, Waste, and Abuse
3011 W. Grand Blvd., Suite 1600
Detroit, MI 48202
Call: (313) 871-6583 or toll-free (800) 826-2862
Fax: (313) 748-1397
You may also report instances of FWA directly to the Office of Inspector General by sending a memo or letter to:

Michigan Department of Health and Human Services
Office of Inspector General
PO Box 30062
Lansing, MI 48909

Or, you may call the 24-hour hotline at: (855) MI-FRAUD (643-7283) toll free, visit the website at www.michigan.gov/fraud, or send an email to MDHHS-OIG@michigan.gov. You do not have to give your name.