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 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:
What is the overall deductible?	For network providers $1,500 person/ $3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The deductible doesn't apply to preventive care, certain services subject to a flat dollar copay, Prescription drugs, Allergy testing, pediatric vision services, adult vision services, weight loss, Diabetes and nutrition counseling, DME from network provider.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $7,000 person/ $14,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charge, health care this plan doesn't cover, copays for non-essential health services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.THCmi.com or call 1-800-826-2862 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, Chiropractic/Podiatric visits require a written PCP referral. No referral for other specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible does not apply.	Not Covered	None
	Specialist visit	$60 copay/visit, deductible does not apply.	Not Covered	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	Not Covered	Preventive care services are those listed in THC's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray) Blood work	$100 copay/visit, deductible does not apply. No charge/visit	Not Covered	Subject to co-insurance when services provided in outpatient or inpatient facility setting.
	Imaging (CT/PET scans, MRIs)	$400 copay/visit, deductible does not apply.	Not Covered	Written PCP referral required. Subject to co-insurance when services provided in outpatient or inpatient facility setting.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://thcmi.com/pharmacy/.	Generic drugs (Tier 1)	$25 copay/retail prescription $50 copay/mail order prescription	Not Covered	Retail prescription: up to 30-day supply Mail order prescription: 90- day supply
	Preferred brand drugs (Tier 2)	$50 copay/retail prescription $100 copay/mail order prescription	Not Covered	Prior authorization and step therapy apply to select drugs. Retail prescription: up to 30-day supply. Mail order prescription: 90- day supply.
	Non-preferred brand drugs (Tier 3)	$100 copay/retail prescription $200 copay/mail order prescription	Not Covered	Prior authorization and step therapy apply to select drugs. Retail prescription: up to 30-day supply. Mail order prescription: 90- day supply.
	Specialty drugs (Tier 4)	30% coinsurance per prescription.	Not Covered	Prior authorization and step therapy apply to select drugs. Specialty Prescription: up to 30-day supply. Dispensing pharmacy may vary.

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Written PCP referral required.
	Physician/surgeon fees	No Charge	Not Covered	Written PCP referral required.
If you need immediate medical attention	Emergency room care	$350 copay/visit, deductible does not apply.	$350 copay/visit, deductible does not apply.	Copay waived if admitted to hospital. Out-of-network may be subject to balance billing.
	Emergency medical transportation	$75 copay/visit, deductible does not apply.	Covered at the in-network benefit level; R&C limitations apply	None
	Urgent care	$60 copay/visit, deductible does not apply.	$60 copay/visit, deductible does not apply.	Out-of-network may be subject to balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Preauthorization is required for elective admissions and Notification required for Emergency and Maternity admissions for vaginal delivery up to 48 hours, cesarean section less than 96 hours.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance use services	Outpatient services (includes ABA services).	$60 copay/visit, deductible does not apply.	Not Covered	Benefits administered through Beacon Health Options. Contact for participating providers and authorization requirements at **1-877-564-8517.**
	Inpatient services	No Charge	Not Covered	
If you are pregnant	Routine prenatal and postnatal care	No Charge, deductible does not apply.	Not Covered	Routine prenatal and postnatal visits are covered under preventive services. Medically necessary maternity care is covered when provided by a participating provider. Services may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Preauthorization required.
	Rehabilitation services	No Charge	Not Covered	Preauthorization 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 limited to a combined 30 visits/year.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility are limited to a combined 45 days per contract year. Preauthorization is required.
	Durable medical equipment	No Charge, deductible does not apply.	Not Covered	Contact THC for authorization requirements.
	Prosthetics & orthotics	No Charge		
	Hospice services	No Charge	Not Covered	Preauthorization is required. This benefit applies to hospice services provided in the home only. Any hospice service provided in a facility will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Children's eye exam	No Charge, deductible does not apply.	Not covered	Coverage limited to one exam/year.
	Children's glasses	No Charge, deductible does not apply.	Not covered	Coverage limited to one select frame and one pair of glasses/year up to age 18 or medically necessary contacts.
	Children's dental check-up	Not covered	Not covered	None

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.)		
• Abortion • Acupuncture • Cosmetic Surgery • Dental care (Adult and Children)	• Infertility treatment (i.e. in-vitro, artificial insemination) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (once per lifetime) • Chiropractic Care • Cosmetic Surgery (medically necessary)	• Emergency services outside of the U.S. • Hearing aids • Infertility Treatment Consult	• Routine Eye Care (Adult) • Telehealth Services • Weight Loss Program

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 the 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 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 on how 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.

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 DD/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.

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.

Nondiscrmination Notice

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 هاتف الصم والبكم: 1-(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: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܠܝܬܐ ܠܟܘܢ ܚܠܦܬܐ ܕܗܝܪܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘ ܥܠ ܡܢܝܢܐ (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 করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ (800) 826-2862 (TTY: 711)।

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。

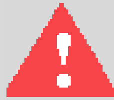
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 826-2862 (TTY: 711).

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).

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	**$2,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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

*For more information about limitations and exceptions, see the plan or policy document at www.THCmi.com.