




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.THCmi.com](http://www.THCmi.com) or call Customer Service at 1-800-826-2862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-826-2862 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For <u>network providers</u> \$5,000 person/ \$10,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. The <u>deductible</u> doesn't apply to <u>preventive care</u> , certain services subject to a flat dollar copay, Allergy testing, pediatric vision services, adult vision services, weight loss, Diabetes and nutrition counseling, DME from network provider.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network providers</u> \$7,900 person/ \$15,800 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charge, health care this <u>plan</u> doesn't cover, copays for non-essential health services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.THCmi.com">www.THCmi.com</a> or call 1-800-826-2862 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes, Chiropractic/Podiatric visits require a written PCP <u>referral</u> . No <u>referral</u> for other <u>specialists</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, deductible does not apply.	Not Covered	None
	<u>Specialist</u> visit	30% <u>coinsurance</u> /visit	Not Covered	None
	<u>Preventive care/screening/immunization</u>	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray)	30% <u>coinsurance</u>	Not Covered	Subject to co-insurance when services provided in outpatient or inpatient facility setting.
	Blood work	30% <u>coinsurance</u>		
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not Covered	Written PCP <u>referral</u> required. Subject to co-insurance when services provided in outpatient or inpatient facility setting.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://thcmi.com/pharmacy/">https://thcmi.com/pharmacy/</a> . <b>**Overall deductible must be met before plan covers prescriptions.</b>	Generic drugs (Tier 1)	\$10 <u>copay</u> , deductible does not apply -retail prescription \$20 <u>copay</u> , deductible does not apply -mail order prescription	Not Covered	Retail prescription: up to 30-day supply Mail order prescription: 90- day supply
	Preferred brand drugs (Tier 2)	\$40 <u>copay</u> -retail prescription \$80 <u>copay</u> -mail order prescription	Not Covered	<u>Prior authorization</u> 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)	30% <u>coinsurance</u> -retail prescription 30% <u>coinsurance</u> - mail order prescription	Not Covered	<u>Prior authorization</u> and step therapy apply to select drugs. Retail prescription: up to 30-day supply. Mail order prescription: 90- day supply.
	<u>Specialty drugs</u> (Tier 4)	30% <u>coinsurance</u> per prescription.	Not Covered	<u>Prior authorization</u> 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](http://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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not Covered	Written PCP <u>referral</u> required.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	Written PCP <u>referral</u> required.
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network may be subject to balance billing.
	<u>Emergency medical transportation</u>	\$75 <u>copay</u> /visit, deductible does not apply.	Covered at the in-network benefit level; R&C limitations apply	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network may be subject to balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> 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	30% <u>coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance use services	Outpatient services (includes ABA services).	\$20 <u>copay</u> /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	30% <u>coinsurance</u>	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 <u>preventive</u> 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	30% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not Covered	

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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	<u>Home health care</u>	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required.
If you need help recovering or have other special health needs If your child needs dental or eye care	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. Physical & Occupational Therapy (including Osteopathic and Chiropractic Manipulation) limited to a combined 30 visits/year. Speech Therapy limited to 30 visits/year. Cardiac & Pulmonary Rehab limited to a combined 30 visits/year.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. Physical & Occupational Therapy (including Osteopathic and Chiropractic Manipulation) limited to a combined 30 visits/year. Speech Therapy limited to 30 visits/year. Cardiac & Pulmonary Rehab limited to a combined 30 visits/year.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	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. <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	No Charge, deductible does not apply.	Not Covered	Contact THC for authorization requirements.
	Prosthetics & orthotics	30% <u>coinsurance</u>	Not Covered Not Covered	Contact THC for authorization requirements. <u>Preauthorization</u> 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.
	<u>Hospice services</u>	30% <u>coinsurance</u>		
	Children's eye exam	No Charge, deductible does not apply.	Not covered	Coverage limited to one exam/year.
If your child needs dental or eye care	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

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

## Excluded Services & Other Covered Services:

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

- 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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](mailto: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.**

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\*For more information about limitations and exceptions, see the plan or policy document at [www.THCMi.com](http://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](mailto:thc@thcmi.com).
- You can file a grievance by mail, fax or email. If you need help filing a grievance, Total Health Care Customer Service is available to help you.

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

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

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





**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** \$5,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,960</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$5,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$3,500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$800
<b>The total Joe would pay is</b>	<b>\$4,600</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$5,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$1,600
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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](http://www.THCMi.com).