Total Health Care: Wayne State University

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: All Contract Types| **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.THCmi.com or by calling 1-800-826-2862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no out-of-pocket limits	Not applicable because there are no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, For network providers see: www.THCmi.com or call 1-800-826-2862.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Plans use the term in-network, **preferred**, or participating **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, for some services	The referral requirement for most specialists has been removed **excluding Chiropractic and Podiatry services.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your Certificate of Coverage for additional information about **excluded services**.

OMB Control Numbers 1545-2229,
1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay /visit	Not covered	——————none——————
	Specialist visit	$10 copay /visit	Not covered	——————none——————--
	Other practitioner office visit	$10 copay /visit	Not covered	——————none——————
	Preventive care/screening/immunization	$10 copay/visit	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	100 % coverage	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	100 % coverage	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.THCmi.com or call 1-800-826-2862.	Generic drugs	$5 copay/ rx	Not covered	Retail prescription: covers up to a 30-day supply Mail order: 90 day supply at 2x co pay
	Preferred brand drugs	$10 copay/rx	Not covered	Retail prescription: covers up to a 30-day supply Mail order: 90 day supply at 2x co pay
	Non-preferred brand drugs	Not covered	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	$10 copay/ rx	Not covered	Prior Authorization required. 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% Coverage	Not Covered	——————none——————
	Physician/surgeon fees	100% Coverage	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	100% Coverage	100% Coverage	——————none——————
	Emergency medical transportation	$75 copay	$75 copay	——————none——————
	Urgent care	100% Coverage	Not Covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	100% Coverage	Not Covered	——————none——————
	Physician/surgeon fee	100% Coverage	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100% Coverage	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	100% Coverage	Not Covered	——————none——————
	Substance use disorder outpatient services	100% Coverage	Not Covered	——————none——————
	Substance use disorder inpatient services	100% Coverage	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	$10 copay (one time copay)	Not Covered	——————none——————
	Delivery and all inpatient services	100% Coverage	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% Coverage	Not Covered	Limited to 100 visits per calendar year
	Rehabilitation services	100% Coverage	Not Covered	Limited to 45 visits per calendar year
	Habilitation services	100% Coverage	Not Covered	——————none——————
	Skilled nursing care	100% Coverage	Not Covered	Limited to 120 visits per calendar year
	Durable medical equipment	100% Coverage	Not Covered	Covered when medically necessary
	Hospice service	100% Coverage	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Dental Care
- Private duty nursing
- Long term care
- Routine foot care
- Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery-prior authorization required
- Chiropractic care – Maximum of 20 office visits
- Cosmetic surgery
- Routine Eye Care (Adult)
- Infertility testing
- Weight loss programs
- Hearing Aids- Limited to one every three years.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and state laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be higher than the premium that you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-826-2862. You may also contact your state insurance department, the U.S. department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. department of Health and Human Services at 1-877-267-2323 xt.61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Total Health Care's Grievance Coordinator, 3011 W. Grand Blvd. Suite 1600 Detroit, MI 48202 or (800) 826-2862.
In addition, to ask general questions about your appeal rights, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the Office of Financial and Insurance Regulation, Health Plan Division, 611 West Ottawa Street, P.O. Box 30220, Lansing, Michigan 48909-7720 or at (517) 373-0220 or toll-free (877)999-6442. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HISAP), Michigan Office of Financial and Insurance Regulation, P.O. Box 30220, Lansing, Michigan 48909 or toll-free at (877) 999-6442, or email at Ofir-hicap@michigan.gov. The website is http://michigan.gov/ofir.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.
(IMPORTANT: Total Health Care is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,020
- **Patient pays** $380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.