Total Health Care USA, Inc.: Wayne State University HMO Plan

Coverage for: Individual or Family | **Plan Type:** HMO

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.heatlhcare.gov/sbc-glosssary or call 1-800-826-2862 to request a copy.

IMPORTANT QUESTIONS	ANSWERS	WHY THIS MATTERS:
What is the overall deductible?	In Network: **$0 annual per member** **$0 annual per family**	See the Common Medical Events chart below for your costs for services this plan covers. 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. Preventive care services are covered before you meet your deductible.	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?	In Network: **$6,350 per member** **$12,700 per family** Out of Network: N/A. Out-of-pocket limit combined for medical and pharmacy.	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 charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
[expires April 5, 2019]

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

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/Podiatry visits require written PCP referral. No referral for other specialists.	This plan will pay some or all of the costs to see a Chiropractic or Podiatric 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 WILL YOU 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	$20 copay/visit	Not covered	-------None-------
	Specialist visit	$20 copay/visit	Not covered	-------None-------
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Covered	Not covered	Tests performed in an outpatient hospital are subject to deductible.
	Imaging (CT/PET scans, MRIs)	Covered	Not covered	Written PCP referral required. Tests performed in an outpatient hospital are subject to deductible.

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COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
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)	$5 copay	Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Preferred brand drugs (Tier 2)	$20 copay	Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Non-preferred brand drugs (Tier 3)	$45 copay	Not covered	Prior authorization and step therapy apply to select drugs. Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Specialty drugs (Tier 4)	$45 copay	Not covered	Prior authorization and step therapy apply to select drugs. Specialty prescription: up to a 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered	Not covered	Written PCP referral required
	Physician/surgeon fees	Covered	Not covered	Written PCP referral required
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Copay waived if admitted or accidental injury
	Emergency medical transportation	$75 copay	$75 copay	When medically necessary
	Urgent care	$20 copay	Not covered	-------None-------
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered	Not covered	Prior approval required
	Physician/surgeon fees	Covered	Not covered	Prior approval required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered	Not covered	Prior approval required
	Inpatient services	Covered	Not covered	Prior approval required

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COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
If you are pregnant	Office visits	Covered	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Covered	Not covered	Depending on the type of services, a [copayment, coinsurance, or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Covered	Not covered	No prior authorization required for hospital stays for a mother & her newborn of up to 48 hrs following vaginal delivery & 96 hrs following cesarean section
If you need help recovering or have other special health needs	Home health care	Covered	Not covered	Prior approval required
	Rehabilitation services	Covered	Not covered	Prior approval required. Physical & Occupational Therapy (including Osteopathic and Chiropractic Manipulation) limited to a combined 45 visits/year. Speech Therapy limited to 45 visits/year. Cardiac & Pulmonary Rehab limited to a combined 45 visits/year.
	Habilitation services	Covered	Not covered	Prior approval required
	Skilled nursing care	Covered	Not covered	Prior approval required for Skilled Nursing Care, Inpatient Rehabilitative Services and Sub Acute Care. Limit to 120 days per calendar year.
	Durable medical equipment	Covered	Not covered	Authorization requirements change frequently. To determine if a service requires authorization, log into www.THCmi.com.
	Hospice services	Covered	Not covered	Prior approval required. Includes Inpatient and Outpatient hospice care.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not covered	1 exam per year
	Children's glasses	Not Covered	Not covered	1 pair per year up to age 18. Limited to 1 pair every 2 years for adults 18 and over.
	Children's dental check-up	Not covered	Not covered	-------None-------

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

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 with the exception of limited services
- Acupuncture
- Dental Care (Adult)
- Infertility Treatment (i.e. in-vitro, artificial insemination)
- Long Term Care
- Routine Foot Care
- Non-emergency care outside of the U.S.A.
- Private-duty nursing

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

- Allergy Testing and Injections
- Bariatric Surgery
- Chiropractic care
- Cosmetic Surgery (Medically Necessary)
- Durable Medical Equipment
- Emergency Services outside of the U.S.A.
- Hearing aids
- Infertility Treatment Consult
- Routine Eye Care (Adult)
- Weight Loss Programs

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

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

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

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

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

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

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

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, or sex.

Total Health Care:

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

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

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

- Total Health Care Civil Rights Coordinator, 3011 W. Grand Blvd, Suite 1600, Detroit MI 48202, (800) 826-2862 (TDD/TTY: 711), Fax: (800) 826-6406 or email: thc@thcmi.com.
- 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.

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Nondiscrimination 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 رقمهاتف الصم والبكم: (800) 826-2862--1 (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 ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝܬܘܢ ܕܡܣܬܥܝܢܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ 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).

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

About these Coverage Examples:

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

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

• **The plan's overall deductible**	**$0**
• **Specialist *[cost sharing]***	**$20**
• **Hospital (facility) *[cost sharing]***	**$0**
• **Other *[cost sharing]***	**$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	**$12,840.00**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$460.00**

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

• **The plan's overall deductible**	**$0**
• **Specialist *[cost sharing]***	**$20**
• **Hospital (facility) *[cost sharing]***	**$0**
• **Other *[cost sharing]***	**$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	**$7,460.00**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$615.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55.00
The total Joe would pay is	**$670.00**

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

• **The plan's overall deductible**	**$0**
• **Specialist *[cost sharing]***	**$20**
• **Hospital (facility) *[cost sharing]***	**$0**
• **Other *[cost sharing]***	**$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	**$2,010.00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$585.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$585.00**

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