



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, visit us at [mclarenhealthplan.org](http://mclarenhealthplan.org) or call Customer Service at (888) 327-0671. 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 (888) 327-0671 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For Tier 1 Providers: \$500/person / \$1,000/family For Tier 2 Providers: \$2,000/person / 4,000/family For Out-of-Network Providers: \$2,000/person / 4,000/family                                                                    | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                          |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes, the deductible doesn't apply to <a href="#">preventive care</a> for Tier 1 Providers, and certain services subject to flat dollar <a href="#">copayments</a> .                                                                    | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.                                                                                                                                                                                                                                    | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For Tier 1 and Tier 2 Providers: \$9,200/person / \$18,400/family For Out-of-Network Providers: \$15,000/person / \$30,000/family Discounts, coupons, or similar financial assistance provided by drug manufacturers are not included. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                       |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover. Discounts, coupons or similar financial assistance provided by drug manufacturers are not included.        | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Important Questions                                                          | Answers                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="http://www.McLarenHealthAdvantage.org">www.McLarenHealthAdvantage.org</a> or call (888) 327-0671 for a list of <a href="#">network providers</a> . | This plan uses a <a href="#">provider</a> network. You will pay less if you use a provider in the <a href="#">plan's</a> network (a " <a href="#">Participating Provider</a> "). You will pay more if you use Tier 2 Provider. You will pay the most if you use a <a href="#">non-Participating Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">Provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">Participating Provider</a> might use a <a href="#">non-Participating Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.                                                                                                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

 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                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Tier 1 Provider<br>(You will pay the least)                                         | Tier 2 Provider<br>(You will pay more) | Non-Participating Provider<br>(You will pay the most)               |                                                                                                                                                                                                                                                                                                                                |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$25 <a href="#">Copayment</a> / visit<br><a href="#">Deductible</a> does not apply | 50% <a href="#">Coinsurance</a> ;      | 50% <a href="#">Coinsurance</a> plus <a href="#">Balance Bill</a> ; | None.                                                                                                                                                                                                                                                                                                                          |
|                                                                        | <a href="#">Specialist</a> visit                       | \$40 <a href="#">Copayment</a> / visit<br><a href="#">Deductible</a> does not apply | 50% <a href="#">Coinsurance</a> ;      | 50% <a href="#">Coinsurance</a> plus <a href="#">Balance Bill</a> ; | <a href="#">Plan Preauthorization</a> for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment.                                                                                                                                        |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge<br><a href="#">Deductible</a> does not apply                              | Not Covered                            | Not Covered                                                         | <a href="#">Plan Preauthorization</a> for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your |

| Common Medical Event                                                                                                                                                                                                                                                                                                                                              | Services You May Need                                                                    | What You Will Pay                                                        |                                                                                                                                  |                                                                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          | Tier 1 Provider<br>(You will pay the least)                              | Tier 2 Provider<br>(You will pay more)                                                                                           | Non-Participating Provider<br>(You will pay the most)                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          |                                                                          |                                                                                                                                  |                                                                                                                                  | Plan will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| If you have a test                                                                                                                                                                                                                                                                                                                                                | <a href="#">Diagnostic test</a> (x-ray, blood work)                                      | 20% <u>Coinurance</u>                                                    | 50% <u>Coinurance</u>                                                                                                            | 50% <u>Coinurance</u> plus <u>Balance Bill</u>                                                                                   | Plan <u>Preauthorization</u> is required for genetic testing. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                                                             | 20% <u>Coinurance</u>                                                    | 50% <u>Coinurance</u>                                                                                                            | 50% <u>Coinurance</u> plus <u>Balance Bill</u>                                                                                   | Plan <u>Preauthorization</u> is required. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need drugs to treat your illness or condition<br>More information about <a href="https://www.mclarenhealthplan.org/mh-cc-member/formulary-lookup-mhp">prescription drug coverage</a> is available at <a href="https://www.mclarenhealthplan.org/mh-cc-member/formulary-lookup-mhp">https://www.mclarenhealthplan.org/mh-cc-member/formulary-lookup-mhp</a> | Generic drugs – Tier 1 (Preferred Generic drugs)                                         | \$10 <u>Copayment</u> / Prescription<br><u>Deductible</u> does not apply | \$10 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. | \$10 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. | Plan <u>Preauthorization</u> is required for some drugs.<br>See the Plan Formulary at <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx</a><br><br>A 90-day supply of Brand Name Drugs or Generic Drugs may be dispensed from a Mail Order or Retail Pharmacy if a Member successfully completes a 30-day trial of the Drug. If a copayment applies, the 90-day supply may be obtained with one <u>Copayment</u> .<br><br>The penalty for not having prior authorization is denial of payment. |
|                                                                                                                                                                                                                                                                                                                                                                   | Preferred brand drugs – Tier 2 (Preferred brand drugs)                                   | \$30 <u>Copayment</u> / Prescription<br><u>Deductible</u> does not apply | \$30 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. | \$30 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                   | Non-preferred brand drugs – Tier 3 (Non-preferred generic and non-preferred brand drugs) | \$50 <u>Copayment</u> /Prescription<br><u>Deductible</u> does not apply. | \$50 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. | \$50 <u>Copayment</u> / Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Specialty drugs – Tier 3</a>                                                 | If obtained through the MedImpact Assist Program -                       | \$50 <u>Copayment</u> / Prescription plus 25% of                                                                                 | \$50 <u>Copayment</u> / Prescription plus 25% of Reasonable                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                                                        |                                                                                 |                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Tier 1 Provider<br>(You will pay the least)                                                                                                                                                                              | Tier 2 Provider<br>(You will pay more)                                          | Non-Participating Provider<br>(You will pay the most)                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                         |                                                  | Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program <u>Deductible</u> does not apply<br><br>All other - \$50 Copayment/Prescription <u>Deductible</u> does not apply | Reasonable and Customary Amount Paid by Plan. <u>Deductible</u> does not apply. | and Customary Amount Paid by Plan. <u>Deductible</u> does not apply.             | Only Brand Drugs are Covered. <u>Plan Preauthorization</u> is required. See the Plan Formulary at <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx</a><br>The penalty for not having prior authorization is denial of payment.<br><br>For drugs subject to the MedImpact Assist Program, in no case will true out-of-pocket costs to the Member be greater than a \$50 Copayment for a fill. |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 20% <u>Coinsurance</u>                                                                                                                                                                                                   | 50% <u>Coinsurance</u>                                                          | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                  | Plan <u>Preauthorization</u> for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                      |
|                                         | Physician/surgeon fees                           | 20% <u>Coinsurance</u>                                                                                                                                                                                                   | 50% <u>Coinsurance</u>                                                          | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$150 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                                                                                                                                       | \$150 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply              | \$150 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply               | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                         | <a href="#">Emergency medical transportation</a> | No Charge                                                                                                                                                                                                                | No Charge                                                                       | Provider <u>Balance Bill</u>                                                     | Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> . *Surprise billing rules prohibiting balance billing may apply for certain air ambulance services                                                                                                                                                                                                                                                                                    |
|                                         | <a href="#">Urgent care</a>                      | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                                                                                                                                        | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply               | \$50 <u>Copayment</u> / visit plus <u>Balance Bill</u><br><u>Deductible</u> does | Urgent care from a Non-Participating Provider may result in a <u>balance bill</u> .                                                                                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                    |                                                                      |                                                                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                              |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Tier 1 Provider<br>(You will pay the least)                          | Tier 2 Provider<br>(You will pay more)                               | Non-Participating Provider<br>(You will pay the most)                                         |                                                                                                                                                                                                     |
|                                                                           |                                           |                                                                      |                                                                      | not apply                                                                                     |                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | Plan <u>Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.) The penalty for not having prior authorization is denial of payment.                 |
|                                                                           | Physician/surgeon fees                    | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               |                                                                                                                                                                                                     |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 <u>Copayment</u> /visit<br><u>Deductible</u> does not apply     | 50% <u>Coinsurance</u> ;                                             | 50% <u>Coinsurance</u> plus <u>Balance Bill</u> ;                                             | None.                                                                                                                                                                                               |
|                                                                           | Inpatient services                        | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | Plan <u>Preauthorization</u> is required for the service to be Covered. The penalty for not having prior authorization is denial of payment.                                                        |
| If you are pregnant                                                       | Office visits                             | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                        |
|                                                                           | Childbirth/delivery professional services | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               |                                                                                                                                                                                                     |
|                                                                           | Childbirth/delivery facility services     | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               |                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | Plan <u>Preauthorization</u> is required for the service to be Covered. Housekeeping services and custodial care are excluded. The penalty for not having prior authorization is denial of payment. |
|                                                                           | <a href="#">Rehabilitation services</a>   | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | Limited to 60 visits, per condition, per Plan year.                                                                                                                                                 |
|                                                                           | <a href="#">Habilitation services</a>     | ABA Services - 20% <u>Coinsurance</u><br><br>All other – Not Covered | ABA Services - 50% <u>Coinsurance</u><br><br>All other – Not Covered | ABA Services - 50% <u>Coinsurance</u> plus <u>Balance Bill</u><br><br>All other – Not Covered | Plan <u>Preauthorization</u> is required for ABA Services to be Covered. The penalty for not having prior authorization is denial of payment.                                                       |
|                                                                           | <a href="#">Skilled nursing care</a>      | 20% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u>                                               | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>                                               | 120 days annual maximum                                                                                                                                                                             |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                           |                                        |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                    |
|----------------------------------------|-------------------------------------------|---------------------------------------------|----------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Tier 1 Provider<br>(You will pay the least) | Tier 2 Provider<br>(You will pay more) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                           |
|                                        | <a href="#">Durable medical equipment</a> | 20% <u>Coinsurance</u>                      | 50% <u>Coinsurance</u>                 | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>       | Durable medical equipment with a purchase price of \$5,000 or more or a rental cost of \$500 or more per month requires <u>Plan Preauthorization</u> . See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment. |
|                                        | <a href="#">Hospice services</a>          | 20% <u>Coinsurance</u>                      | 50% <u>Coinsurance</u>                 | 50% <u>Coinsurance</u> plus <u>Balance Bill</u>       | None                                                                                                                                                                                                                                                                      |
| If your child needs dental or eye care | Children's eye exam                       | Not covered                                 | Not covered                            | Not covered                                           | None                                                                                                                                                                                                                                                                      |
|                                        | Children's glasses                        | Not covered                                 | Not covered                            | Not covered                                           | None                                                                                                                                                                                                                                                                      |
|                                        | Children's dental check-up                | Not covered                                 | 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](#).)

- |                           |                                                      |                            |
|---------------------------|------------------------------------------------------|----------------------------|
| • Acupuncture             | • Habilitative Care                                  | • Private-duty nursing     |
| • Cosmetic surgery        | • Hearing aids                                       | • Routine eye care (Adult) |
| • Dental care (Adult)     | • Long-term care                                     | • Routine foot care        |
| • Dental care (Pediatric) | • Non-emergency care when traveling outside the U.S. |                            |

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

- |                     |                        |
|---------------------|------------------------|
| • Bariatric surgery | • Infertility services |
| • Chiropractic care | • 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Health Insurance 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: McLaren Health Advantage, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also contact the

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

Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al (888) 327-0671.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 327-0671.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (888) 327-0671.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (888) 327-0671.

*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.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

#### 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,570</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

#### 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> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$800          |
| <a href="#">Coinsurance</a>       | \$80           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,400</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

#### 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> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,100</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.