McLaren

HEALTH ADVANTAGE

Benefit Booklet and Member Cost Sharing Schedules 2027

Premier Plus

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INTRODUCTION

McLaren Health Care Corporation (the "**Corporation**") sponsors the McLaren Health Care Employee Benefit Plan (the "**Employee Benefit Plan**") for your benefit and the benefit of your family, if you are an eligible employee of the Corporation or its subsidiaries that participate in the Plan.

This document explains the terms and conditions of the McLaren Health Advantage Program (also referred to as the "Medical Benefit Program") that provides comprehensive major medical and hospitalization benefits as well as prescription drug benefits. The McLaren Health Advantage Program ("**Plan**") is a benefit program under the Employee Benefit Plan.

The Plan is a Preferred Provider Organization (PPO) plan administered by McLaren Health Advantage. The Plan is a tiered network and has different coverages levels depending on the provider. You will receive the lowest Out-of-Pocket Expenses at a Tier 1 Provider. Tier 2 Providers are contracted with the Plan but have higher cost-sharing and Out-of-Pocket Expenses. Out-of-Network Providers do not have contracts with the Plan and will in most cases have the highest Out-of-Pocket expenses. You may choose to obtain services from a Tier 1 Provider, Tier 2 Provider or an Out-of-Network Provider, but in most cases you will have higher Member Out-of-Pocket Expenses (e.g., higher Copayments and Deductibles) if you receive services from an Out-of-Network Provider than if you received the services from a Tier 1 Provider or Tier 2 Provider. A provider's benefits tier may change from time to time.

IMPORTANT INFORMATION

- The Plan Covers the Benefits listed in this Benefits Document only when they are:
  - Provided in accordance with the terms of this Benefits Document; and
  - When required, Preauthorized or approved by the Plan.
- The Benefits listed in your Benefits Document, Schedule of Member Cost Sharing and any Riders are Covered only when they are Medically Necessary. Medical Necessity is determined by the Plan and the Plan's Chief Medical Officer).
- You are responsible for Deductibles, Copayments, and Coinsurance for many of the Benefits listed (See Section 7.02).
- The Plan does not limit Coverage based on genetic information, and it will not adjust premiums based on genetic information, request/require genetic testing or collect genetic information from an individual at any time for underwriting purposes.
- No eligibility rules or variations in premium rates or the cost for the Medical Benefit Program will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Variations in the administration, processes or benefits of this Medical Benefit Program that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs are not considered discrimination.
- Unless an Applicable Surprise Billing Law, you may be Balance Billed when you see an Out-of-Network Provider. This may include Surprise billing laws do not cover all services and in some cases you could consent to Balance Billing.
- When you see an In-Network Provider, you should always request to have your labs, pathology and other services sent to an In-Network Provider in order to avoid Balance Billing. Failure to do so may result in significant costs to you. Except if required by an Applicable Surprise Billing Law, we will not pay for labs, pathology and other services sent to an Out-of-Network Provider at the In-Network Cost Sharing. Labs, pathology and other services that are considered Preventive Services and are sent to an Out-of- Network Provider will not be paid for and are not Covered, unless the service cannot be provided by any In-Network Provider.

ANTI-DISCRIMINATION:

The Corporation and McLaren Health Advantage (collectively, "**McLaren**") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

McLaren:

- 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 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 McLaren Health Advantage's Compliance Officer.

If you believe that McLaren 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 McLaren Health Advantage's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48507, call: (866) 866-2135, TTY 711, Fax: (877) 733-5788, or Email mhpcompliance@mclaren.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, McLaren Health Advantage's Compliance Officer 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 https://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 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:
ܬܘܫܡܪܬܐ: ܐܢ ܐܢܬ ܡܬܟܠܡ ܠܫܢ̈ܐ ܣܘܪܝܝܐ، ܐܝܟ ܒܪ ܡܫܘ ܐܝܬ ܠܟ ܫܘ̈ܬܦ̈ܐ ܕܫܘ̈ܬܦ̈ܐ ܕܡܠܬܐ ܕܡܬܝܗܒ̈ܝܢ ܠܟ ܒܠܐ ܡܚܐܪ.
ܩܪܘ ܠ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（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 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (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。1-888-327-0671（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 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

DEFINITIONS

These definitions will help you understand the terms used in this Benefits Document.
Acute Illness or Injury is one that is characterized by sudden onset (e.g., following an injury) or presents an exacerbation of disease and is expected to last a short period of time after treatment by medical or surgical intervention.

Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim.
- a failure to provide or make payment, in whole or in part, of the benefit for which you filed a Claim, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.
- a retroactive cancellation of coverage, except for a retroactive cancellation of coverage for failure to timely pay required premiums or contributions.

Applicable Surprise Billing Laws means the applicable surprise billing and cost-sharing protections set forth in PHS Act sections 2799A-1 and 2799A-2 and 45 CFR §§ 149.110 through 149.130.

Approved Clinical Trial means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

Balance Billing means an amount the Member must pay after the Plan has paid its Reimbursement Amount for a Covered Service. Unless the Covered Service is subject to Applicable Surprise Billing Laws, when a Covered Service is obtained from an Out-of-Network Provider who is not a Secondary Network Provider, the Plan will pay the Provider the Reimbursement Amount for the Covered Service. If the provider's charge is greater than the amount paid by the Plan, the balance is referred to as a "Balance Bill" which will be the responsibility of the Member to pay. NOTE – Unless the Covered Service is subject to Applicable Surprise Billing Laws, Balance Billing will apply when a member receives Out-of-Network Covered Services and is approved for payment at the Tier 1 Provider Benefit Level (see Section 7.03.02 for applicability), and the Covered Services are obtained from an Out-of-Network Provider.

Behavioral Health Provider is a psychiatrist, licensed consulting psychologist, social worker, hospital or other facility duly licensed, accredited and qualified to provide mental health and/or substance abuse services under the law or jurisdiction in which treatment is received.

Benefit is a Covered health care service available to a Member as described in the Benefit Document.

Benefits Document is the booklet we issue to you that describes your Coverage. Benefits Document includes this document, the Schedule of Member Cost Sharing and any riders or amendments to the Benefits Document.

Chief Medical Officer means the Plan's Medical Director or a designated representative.

Chronic means a disease or ailment that is not temporary or recurs frequently. Arthritis, heart disease, major depression and schizophrenia are examples of Chronic diseases.

Claim means any request for a Benefit under the Plan made by the Member or the Member's authorized representative that complies with the Plan's reasonable procedures for making Benefit Claims.

Coinsurance is a percentage of the Plan's Reimbursement Amount that the Member is responsible to pay for certain Benefits. The Coinsurance applies to the Out-of-Pocket Maximum. Refer to your Schedule of Member Cost Sharing to verify your Coinsurance amounts.

Copayment means the fixed amount (for example, $25) you pay for a Covered Services, usually when you receive the service. The amount can vary by the type of Covered Service.

Covered Services, Coverage, Cover or Covered means those Benefits that the Member is entitled to under the Plan, if they are Medically Necessary and have met all other requirements of the Plan. This Benefits Document describes what the Plan will pay for some services and supplies.

Deductible is the annual amount of money payable by a Member for Covered Services. A Member's Deductible is included in Schedule of Member Cost Sharing. The Deductible applies to your Out-of-Pocket Maximum. NOTE – there are multiple deductibles that must be met depending on the provider that you use. Amounts applied toward one deductible do not apply towards another deductible.

Domestic Provider means any McLaren owned hospital.

Health Benefit Plan Option means the Plan Benefit package you have selected for the Plan Year from the several health care Benefit packages offered by the Plan. Health Benefit Plan Options variations include, without limitation, Provider Network requirements and amounts Members are required to pay out-of-pocket. Refer to your Schedule of Member Cost Sharing for information specific to your Health Benefit Plan Option.

Hospital is a state-licensed, acute-care facility that provides continuous, 24-hour inpatient medical, mental health, substance abuse, surgical, or obstetrical care. It is not primarily a nursing care

facility, rest home, home for the aged, or a facility to treat substance abuse, psychiatric disorders, or pulmonary tuberculosis.

Infertility means a disease, condition, or status characterized by:

- a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility;
- a Member's inability to reproduce either as a single individual or with a partner without medical intervention; or
- a licensed physician's findings based on a Member's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Inpatient Service is a service provided during the time a patient is admitted to a Hospital or Skilled Nursing Facility.

Tier 1 Provider means a Provider that is either (1) a McLaren owned or employed provider, or (2) certain other health care providers directly contracted with McLaren Health Advantage listed in the Provider Directory as Tier 1 Providers. Benefits received from Tier 1 Providers are provided at the lowest Out-of-Pocket Expense to the Member. The list of Tier 1 Providers can be found in the McLaren Health Advantage Provider Directory located at www.McLarenHealthPlan.org. See also **Tier 2 Providers** and **Out-of-Network Providers**.

Tier 2 Provider means a Provider that is not a Tier 1 Provider but is directly contracted with McLaren Health Advantage listed in the Provider Directory as Tier 2 Providers. The list of Tier 2 Providers can be found in the McLaren Health Advantage Provider Directory located at www.McLarenHealthPlan.org. When you obtain services from Tier 2 Providers, your Out-of- Pocket Expenses will be higher than the Out-of-Pocket Expenses if you obtain the services from a Tier 1 Provider.

McLaren Health Advantage is your medical and pharmacy benefit program. It is also the name of the company that provides administrative services for the Plan.

Medically Necessary means services or supplies furnished by a Hospital, physician, or other provider that is the most economical and efficient care to identify or treat an illness or injury that is determined by McLaren Health Advantage to be:

- Accepted as necessary and appropriate for the patient's condition. For diagnostic services, the results are essential to the diagnosis, care, treatment, and/or management of the patient's condition.
- The most appropriate supply or level of services that can be safely provided to the patient. When applied to an Inpatient Service, it means that the patient's medical symptoms or conditions require that the services or supplies cannot be safely provided to the patient in an outpatient setting.
- Appropriate with regard to standards of good medical practice. Based upon recognized standards of health care specialty involved, it must be based on generally accepted medical

or scientific evidence as:

- Treatment that is to the Member's diagnosis or condition in terms of type, amount, frequency, level, setting and duration;
- Effective treatment;
- Essential Treatment; and
- Not cosmetic in nature.

Member is the Subscriber or an eligible dependent covered by and entitled to Benefits under this Plan. In Plan documents, "Member" is sometimes also referred to as "Covered Person".

Mental Health Provider is a psychiatrist, licensed consulting psychologist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received.

Newborn is a child 30 days old or younger.
Out-of-Network Provider means a provider that is not a Tier 1 Provider or Tier 2 Provider. When you obtain services from Out-of-Network Providers, your Out-of-Pocket Expenses will be higher than the Out-of-Pocket Expenses if you obtain the services from a Tier 1 or Tier 2 Provider.

Out-of-Pocket Expense means costs for Covered Services for which the Member is responsible. These include the annual Deductible, Copayments, Coinsurance and Balance Billing.

Out-of-Pocket Maximum is the maximum total amount you must pay for your medical and pharmacy Deductible, Copayments and Coinsurance during a Plan Year. This limit does not include your premium, Balance Billing or health care services or supplies that are not Covered Services by the Plan. **NOTE** – see your pharmacy benefit in Section 7.31 for additional information on limitations and exclusions to the Out-of-Pocket Maximum. **NOTE** – you have a different Out-of-Pocket Maximums depending on the provider you see. See your Schedule of Member Cost Sharing for details.
Plan Year means the 12-month calendar period beginning on each January 1 and ending on the subsequent December 31.

Preauthorized Service, **Preauthorization or Preauthorize** relates to a Benefit that is required to be authorized or approved by the Plan prior to obtaining the care or service. If such a service is not authorized or approved, it is either (1) not a payable Benefit unless provided as an emergency or urgent care service; or (2) if a payable Benefit, payable with higher Out-of-Pocket Expense to the Member. See Section 7.03 for more information about when and how to obtain Preauthorization.

Primary Care Physician or PCP is a licensed medical doctor (MD) or doctor of osteopathy (DO). Members are required to select a PCP. If you do not elect a PCP, one will be selected for you based on your zip code. For women, an OB/GYN may be selected as your PCP. For Members under the age of 18 years, a pediatrician may be the child's PCP. Your PCP can provide, arrange and coordinate all aspects of your health care to help you receive the right care, in the right place, at the right time.

Provider Directory is a listing of the names and locations of health care providers who are Tier 1 Providers and Tier 2 Providers. You may call our Customer Service Department to obtain a list of Providers in your area, or you can go to our website at www.McLarenHealthPlan.org.

Qualifying Payment Amount has the same definition that applies in Applicable Surprise Billing Laws.

Reimbursement Amount is the maximum amount determined by McLaren Health Advantage to be eligible for payment for a particular service, supply or procedure that the Plan will pay for a Benefit. For Tier 1 Providers or Tier 2 Providers it is the lower of the billed charge or the contracted amount that the Plan pays the Tier 1 Provider or Tier 2 Provider based on the McLaren Health Advantage's contracted rate with the provider in effect on the date of service, less any applicable cost-sharing. For Out-of-Network Providers, it is the lower of the billed charge or the Reimbursement Amount the Plan will pay an Out-of-Network Provider, in accordance with the Reimbursement Methodology in the chart below, less any applicable cost- sharing. When the Reimbursement Amount for Out-of-Network Providers is developed from base Medicare Participating reimbursements, it will exclude any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim (*e.g.*, graduate medical education payments. When a particular service is reimbursed using a Medicare reimbursement rate and the Medicare reimbursement rate is not available or is unable to be determined based on the Claim information submitted, the Reimbursement Amount for Out-of-Network Providers will be the median rate for In-Network Providers for the service, supply or procedure. For Emergency Services, as defined in Section 7.08 and for Emergency Air Ambulance Services, provided by an Out-of-Network Provider, reimbursement will be no more than the Qualifying Payment Amount, or if the Plan cannot determine the Qualifying Payment Amount, it will use the Secondary Network. Additionally, for Emergency Services, if Applicable Surprise Billing Laws do not apply, reimbursement will be at the non-Emergency Out-of-Network Reimbursement Methodology specified below. Unless subject to an Applicable Surprise Billing Law, the following contains the non-Emergency Services Out-of-Network Reimbursement Methodology:

Provider Type	Reimbursement Methodology
Out-of-Network Professional	100% of Medicare Allowable
Out-of-Network ASC	100% of Medicare ASC Repricing
Out-of-Network Hospital	60% of Billed Charges
Out-of-Network Skilled Nursing Facility	60% of Billed Charges
Out-of-Network DME	100% of the Michigan Medicare Allowable
Ground Ambulance	100% of Billed Charges
Emergency Air Ambulance	Qualifying Payment Amount
Out-of-Network Pharmacy	Tier 1 – (Preferred Generic) 25% of Average Wholesale Price (AWP) Tier 2 – (Preferred Brand) 75% of AWP Tier 3 – (Non-Preferred Generic) 25% of AWP Non-Preferred Brand 70% of AWP Specialty Drugs 70% of AWP Preventive AWP 75% of AWP

NOTE – Only to the extent required by law, the Plan will comply with Applicable Surprise Billing Laws. To the extent required by an Applicable Surprise Billing Law, cost-sharing will be calculated at the Qualifying Payment Amount.

Rehabilitation Services are health care services that help a person keep, get back or improve skills and functions for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Schedule of Member Cost Sharing means the document included as a part of this Benefits Document that details a Member's Provider options and any Copayment, Coinsurance and/or Deductible that is the Member's responsibility. The Schedule of Member Cost Sharing also includes some conditions of coverage (for example, a limit on the number of visits per year). Although a service is listed in the Schedule of Member Cost Sharing, it may require Plan Preauthorization in order to be a payable Benefit. Benefits are subject to all conditions, exclusions and/or limitations contained in this Benefits Document.

Secondary Network Provider means a GlobalCare/Zelis that have contracted directly with the Plan. Access to GlobalCare/Zelis is limited to certain circumstances. See Section 7.01.01 below for more information.

Self-refer means obtaining services from a Tier 2 Provider or Out-of-Network Provider. In most cases, when a Member self-refers to a Tier 2 Provider or Out-of-Network Provider, the Member is responsible for the higher Tier 2 Provider or Out-of-Network Out-of-Pocket Expenses, as applicable.

Skilled Nursing Facility is a state-licensed, certified nursing home that provides a high level of specialized care to Members. It is an alternative to extended hospital stays.

Subscriber is the eligible employee or retiree who has enrolled for health Coverage with this Plan. In this Benefits Document, this person is also referred to as "Member". In Plan documents, this person is also referred to as the "Participant".

Terminal Illness means a medical or surgical condition for which an individual has a medical prognosis that his/her life expectancy is six (6) months or less if the illness runs its normal course.

Urgent Preauthorization Request means a request for medical care or treatment for which resolution within the Plan's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of the Member or the ability to regain maximum function, or, in the opinion of the treating Provider, would subject the Member to severe pain that could not be adequately managed without the requested service.

PART 1: MEMBER RIGHTS AND RESPONSIBILITIES

1.01 CONFIDENTIALITY OF HEALTH CARE RECORDS

Your health care records will be kept confidential by the Plan in accordance with all applicable state and federal privacy laws. The Plan will only use and disclose your health care information as permitted by law and as described in the Plan's Privacy Notice.

It is your responsibility to cooperate with the Plan by providing health history information and helping to obtain prior medical records at the Plan's request.

1.02 INSPECTION OF MEDICAL RECORDS

You have the right to access your own medical records or those of your minor dependent at physicians' medical offices during regular office hours. You also have the right to access such records at hospitals or other facilities, but you must contact their offices to make arrangements for the records to be available. Access to records of a minor without a minor's consent may be limited by law or applicable Plan policy.

1.03 PRIMARY CARE PHYSICIAN (PCP)

McLaren Health Advantage generally requires the designation of a Primary Care Provider. We encourage you to select a PCP in your geographic area. You have the right to designate any Primary Care Provider who is a Tier 1 Provider and who is available to accept you or your family members. If you do not select a PCP, one will be assigned to you. To select a Tier 1 Provider PCP, please call Customer Service at (888) 327-0671. We can assist you with your request and verify that the PCP you have chosen is accepting new patients. You may also visit our website at www.McLarenHealthPlan.org for the current Provider Directory.

For children under the age of 18 years, you may designate a pediatrician as the Primary Care Provider.

You do not need Prior Authorization from McLaren Health Advantage or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Tier 1 Provider Network who specializes in obstetrics or gynecology. The Tier 1 Provider health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Tier 1 health care professionals who specialize in obstetrics or gynecology, contact Customer Service at (888) 327- 0671.

1.04 COMPLAINT, AND APPEALS PROCEDURES

At McLaren Health Advantage, we want to hear your comments so that we can make our services better for our Members. We want you to be able to receive answers to any questions that you have about the Plan. We also want to provide you ways of reaching fair solutions to any problems that you may have with Coverage. When you have any comments or concerns, please call Customer Service at (888) 327-0671. Customer Service will assist you in documenting your complaint/grievance.

1.04.01 STA NDARD INTERNAL APPEALS

Members may file an appeal of an Adverse Benefit Determination with the Plan. See the definition of Adverse Determination in the Definitions Section of this Certificate, and also note than an untimely response to a request may become an Adverse Benefit Determination.

Members or their authorized representative have one hundred eighty (**180**) days from the date of the notification letter to file a written appeal of an Adverse Benefit Determination. You can send your appeal request along with any additional information to:

McLaren Health Advantage
Attn: Member Appeals
G-3245 Beecher Road Flint, MI 48532

Email: MHPAppeals@mclaren.org

Covered Benefits continue pending resolution of the appeal until: the end of the approved treatment period or determination of the appeal, subject to regulatory and contractual obligations. If you wish to have someone else act as your authorized representative to file your appeal, you will need to complete The Plan's authorized representative form which can be found on our website at www.McLarenHealthPlan.org. You may call Customer Service at (888) 327-0671 for a copy to be mailed to you. You may designate an authorized representative at any step of the appeals process.

You may request copies of information relevant to your appeal, free of charge, by contacting Customer Service at (888) 327-0671.

The Plan will provide you with any additional evidence considered, relied upon or generated by the Plan in connection with your appeal, as soon as possible and sufficiently in advance of the date on which the decision is required to be made, so that you have a reasonable opportunity to respond. Before the Plan issues a final Adverse Determination within the required time frames that is based on a new or additional rationale, we will provide you with any new or additional rationale for a denial of your claim or appeal as soon as possible and sufficiently in advance of the date on which the decision is required to be made, so that you have a reasonable opportunity to respond.

Members have the right to ask the Plan to arrange a meeting with the appeal review committee. You may submit written comments, documents, records and other information relating to your appeal to The Plan prior to the hearing date. Members or an authorized representative may attend the meeting in person or by telephone. The Plan's review does not afford deference to the initial Adverse Benefit Determination. The Plan will take into account all comments, documents, records, and other information submitted by you or your authorized representative, without regard to whether such information was submitted or considered in the initial decision. A person not involved in the initial decision and who is not a subordinate of the person who made the initial decision will review the appeal. If the Appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the care.

The Plan has thirty (30) calendar days to complete the internal appeal process for a pre-service appeal request, and sixty (60) days for a post-service appeal request. These time periods may be extended if requested by the Member. You will receive written notification of the final determination within three (3) calendar days after the decision is made. In addition, we may also notify you orally.

1.04.02 EXPEDITED INTERNAL APPEALS

You may request an expedited appeal for a claim involving urgent care. A claim involving urgent care is a claim for medical care or treatment which due to using the Plan's normal time frames would: a) seriously jeopardize your life or health or your ability to regain maximum function, or b) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment as part of your initial request. Whether a claim is a claim involving urgent care is to be determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If your treating physician advises us that he or she believes that due to your medical status, resolution of your appeal within the Plan's normal time frames would seriously jeopardize your life or health or ability to regain maximum function, the expedited appeals process may be utilized.

A request for an expedited appeal may be made orally or in writing. To submit an oral request, call the Plan at (888) 327-0671. The Plan will make reasonable efforts to give the Member prompt oral notice a denial to treat the appeal as expedited, and in all cases will provide the Member with written notice of any denial of the expedited request and the offer of a standard appeal within two (2) days of the time the Plan received the request for an expedited appeal.

If the appeal is accepted as an expedited appeal, the Plan will make a determination concerning your expedited appeal and communicate that to you and your physician as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt of the request for expedited appeal. Generally, the Plan will notify you and your physician of the Plan's decision by telephone. If MHP notifies you by telephone, you and your physician will be provided with written confirmation of this decision within two (2) calendar days after the telephone notification.

If your appeal involves urgent care, you or your authorized representative may file a request for an expedited external review **at the same time** you or your authorized representative files a request for an expedited appeal with the Plan. You will need to follow the procedure explained below under the heading, "Expedited External Appeals". If you choose to file a request for an external expedited review, your internal appeal will be pended until the Internal Review Organization ("**IRO**") determines whether to accept your request for an expedited external review. If the IRO accepts the expedited external appeal, you will be considered to have exhausted the internal appeal process.

1.04.03 CONCURRENT CARE COMPLAINT/GRIEVANCE AND APPEALS

If you have been approved for a course of treatment and: (i) it is determined that Coverage for your course of treatment is to be reduced or terminated before the treatment is completed (whether that is measured by a pre-set time period or a pre-set number of treatments); or (ii) you wish to extend the course of treatment beyond that which was initially authorized, you may file a "**Concurrent Care Claim**" seeking to restore the remainder of the treatment regimen previously approved, or to request an extension of the treatment.
The Plan will make a determination concerning your Concurrent Care Claim and communicate that to you and your physician quickly enough so that you will have sufficient time to appeal the decision before the course of treatment terminates as originally scheduled. However, in the case of a concurrent claim involving urgent care, if you made the claim at least 24 hours before the prescribed period or treatment expired, you will be notified of our decision within 24 hours of receipt of your claim. Most Plan decisions for a Concurrent Care Claim will be communicated to you and/or your physician by telephone. If so, you and your physician will be provided with written confirmation of this decision within two (2) calendar days after the telephone notification.
If you wish to appeal the decision regarding your Concurrent Care Claim, you must do so within enough time to continue the course of treatment without interruption.

A request for an urgent Concurrent Care Claim should be made by telephoning us at (888) 327- 0671. You can send your appeal request along with any additional information to:

McLaren Health Advantage
Attn: Member Appeals
G-3245 Beecher Road Flint, MI 48532

Email: MHPAppeals@mclaren.org

Your appeal will be decided within 72 hours (for an urgent claim), 15 days (for a pre-service claim) or 30 days (for a post-service claim).

1.04.04 EXTERNAL APPEALS

You may file a request for external review if the final appeal of your Claim is denied, in whole or in part, on internal review and your Claim involves medical judgment (as determined by the External Reviewer), a rescission of coverage or if your Claim involves consideration of whether we are complying with Applicable Surprise Billing Laws. You can ask the Plan for an external appeal with an independent review organization (**IRO**). (The IRO is not part of the Plan; it is an independent review entity to contracts with the Plan to review Member appeals.) You must contact the Plan within four (4) months of receiving the Plan's appeal decision to let us know that you want an external appeal. You can send your appeal request along with any additional information to:

McLaren Health Advantage
Attn: Member Appeals
G-3245 Beecher Road Flint, MI 48532
Email: MHPAppeals@mclaren.org

The Plan will assign an accredited IRO to determine whether the request is eligible for an external appeal. Such review will include:

- Whether the claim involves medical judgment, or rescission of coverage or if we are complying with Applicable Surprise Billing Laws.
- Whether the Member was Covered under the Plan when the health care item or service was *requested*; for retroactive reviews, the Plan must determine whether the Member was Covered under the Plan when the health care item or service was *provided*.
- Whether the Benefit denial relates to the Member's failure to meet the Plan's eligibility requirements.
- Whether the Member has exhausted the Plan's internal appeals process (unless the Member is not required to do so under the appeals regulations).
- And, whether the Member has provided all the information and forms needed to process the external review.

Within five (5) business days of receiving the Member's request for external review, the preliminary review of the Member's request will be completed to determine whether it is eligible for an external review based on the above criteria. The Member will be notified of the preliminary review decision.

If the request for external review is eligible, the IRO will perform the external review. Within forty-five (45) days after the IRO receives the external review request, it will provide written notice of the final external review decision to the Member and the Plan.

1.04.05 EXPEDITED EXTERNAL APPEALS

Members may request an expedited external review at the time the Member receives:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Member for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and the Member has filed a request for an expedited internal appeal; or

- A final internal Adverse Benefit Determination, if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Member received emergency services but has not been discharged from a facility.

The Plan will assign an accredited IRO to determine whether the request is eligible for an expedited external appeal. Such review will include:

- Whether the claim involves medical judgment or a rescission of coverage under the circumstances described above (e.g., involves a medical condition for which the timeframe for completion of another appeal step would seriously jeopardize the life or health of the Member).

- Whether the Member was Covered under the Plan when the health care item or service was *requested*; for retroactive reviews, the Plan must determine whether the Member was Covered under the Plan when the health care item or service was *provided*.
- Whether the Benefit denial relates to the Member's failure to meet the Plan's eligibility requirements.
- Whether the Member has exhausted the Plan's internal appeals process (unless the Member is not required to do so under the appeals regulations).
- And, whether the Member has provided all the information and forms needed to process the external review.

The Member will be notified of the preliminary review decision immediately.

If the request is eligible for an expedited review in accordance with the criteria described above, as expeditiously as the Member's medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the expedited external review request, the IRO will provide the Plan and Member notice of its final decision.

1.05 INFORMATION USED TO DETERMINE MEDICAL NECESSITY

You have the right to request and ask for and be given, without cost, a copy of the actual benefit provisions, guidelines, protocol, clinical review criteria or other information used to determine Medical Necessity. All requests must be sent in writing to McLaren Health Advantage, Customer Service, G-3245 Beecher Road, Flint, MI 48532.

PART 2: FORMS, IDENTIFICATION CARDS, RECORDS AND CLAIMS

2.01 FORMS AND APPLICATIONS

Applicants and Plan Members must complete and submit any applications, information or other forms that the Plan requests within reason. You warrant that any information you submit is true, correct, and complete. If you intentionally submit false or misleading information to the Plan or omit any requested information, it may be grounds for refusing an application or for rescinding or terminating your Coverage.

2.02 IDENTIFICATION CARD

McLaren Health Advantage issues identification cards to Members. You must present these cards whenever you receive or seek services from a provider. This card is the property of the Plan. We may request that the card be returned at any time.

To be entitled to Benefits, the person using the card must be the Member for whom all premiums have been paid. If a person is not entitled to receive services, the person must pay for the services received.

If the card is lost or stolen, report it to Customer Service immediately. The contact number for Customer Service is (888) 327-0671.

2.03 MISUSE OF IDENTIFICATION CARD

If any Member does any of the following:

- Misuses the identification card;
- Repeatedly fails to present the card when receiving services from a provider;
- Permits another person to use the card; and/or
- Attempts to defraud or defrauds the Plan

we may confiscate the card, and all rights of the Member under the Plan will terminate on a date designated by the Plan.

2.04 MEMBERSHIP RECORDS

- The Plan will keep Membership records.
- The Plan will not provide Coverage unless information is submitted in a satisfactory format by a Member.
- Any incorrect information submitted to the Plan may (and should) be corrected. You will be responsible for reimbursing the Plan for any services paid by the Plan as a result of the incorrect information.

2.05 CLAIMS

The Plan may make payments directly to providers who have provided Covered Services to you. The Plan also reserves the right to make payment directly to you. When this occurs, you must pay the provider and the Plan is not legally obligated to pay any additional amounts. You cannot assign your right to receive payment from the Plan to anyone else, nor can you authorize someone else to receive your payments for you, including your provider.

All claims for Covered Services should be reported promptly and must give proof of the nature and extent of the expense. Claims must be filed with the Plan within 12 months of the date of service when the charges were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Charges are considered incurred when a treatment or care is given or a procedure performed or the supplies are delivered. Claims filed later than that date will be declined.

PART 3: OTHER PARTY LIABILITY

The Plan does not pay claims or coordinate Benefits for services that are not provided in accordance with the terms of this Benefits Document.

3.01 NONDUPLICATION

The Plan provides each Member with full health care services within the limits of this Benefits Document.

The Plan does not duplicate Benefits or pay more for Covered Services than the actual fees.

Coverage for Member's Benefits will be reduced to the extent that the Benefits are available or payable under any other certificate or policy covering the Member, whether or not a claim for the benefits is made.

One source of benefits will be primary, which means it will pay before the other source, and the other source of benefits will be secondary, which means it will pay after the source of benefits that is primary (first).

3.02 COORDINATION WITH MOTOR VEHICLE ACCIDENT INSURANCE AND WORKERS COMPENSATION

3.02.01 MOTOR VEHICLE ACCIDENT INSURANCE

The Medical Benefit Program's liability for expenses arising out of a motor vehicle accident is based on the type of motor vehicle insurance law enacted by your state. State motor vehicle insurance laws include: no-fault motor vehicle insurance laws; financial responsibility laws; and other motor vehicle liability insurance laws.

If you do not have motor vehicle insurance coverage even though you are legally required to have it, the Plan will not pay any medical expenses arising out of motor vehicle accidents in which you are involved.

No-Fault Motor Vehicle Insurance Laws
This Coverage is always secondary to the no-fault motor vehicle insurance policy and the motor vehicle insurance policy will pay primary. That is, Covered services and treatment for any motor vehicle-related injury will be paid by this Plan secondary and only up to $5,000. For accidents where another state's insurance laws are determinative, if the relevant state's no-fault act does not provide for a policy alternative whereby motor vehicle coverage can be made secondary, nor mandates that the motor vehicle insurer pay secondary, the Plan pays secondary for Covered medical care expenses arising out of motor vehicle accidents. The Plan has the right to seek reimbursement from the motor vehicle insurer for any health care expenses related to a motor vehicle accident paid by this Plan in excess of this limitation.

Financial Responsibility Law
The motor vehicle insurance policy will pay primary and this Plan pays secondary up to a limit of $5,000 for Covered medical care expenses arising out of motor vehicle accidents.

If the state has a "financial responsibility" law that does not allow the Plan to be secondary, or that does not allow the Plan to subrogate or recover its payments, the Plan will pay any benefits related to a motor vehicle accident on a primary basis, but only to the extent such state law is not preempted by ERISA.

Other Motor Vehicle Liability Insurance
If the state does not have a no-fault motor vehicle insurance law, nor a "financial responsibility" law, the Plan is secondary to motor vehicle insurance coverage or to any other person or entity who caused the accidents or who may be liable for your medical expenses pursuant to the general rule for set forth below in 3.03 Coordination of Benefits (COB) and Subrogation.

3.02.02 WORKERS' COMPENSATION

Services and treatment for any work-related injury that are paid or payable under any workers' compensation program will not be paid by the Plan. If any such services are provided by the Plan, the Plan has the right to seek reimbursement from the other program or insurer.

3.03 COORDINATION OF BENEFITS (COB) AND SUBROGATION

Note: For purposes of this Section, "certificate" and "policy" include a certificate, contract, plan or policy, group or individual, issued by or provided by:

- A health or medical care corporation;
- A hospital service corporation;
- An HMO;
- A long-term care contract, medical care component (such as skilled nursing care);
- A dental care corporation;
- An insurance company;
- A labor-management trustee plan;
- A union welfare plan;
- An employer organization plan; or
- An employer self-insured plan

in connection with a benefit plan under which health, hospital, medical, surgical, or sick care benefits are provided to Members.

Member Responsibility: At the time of enrollment and if requested by the Plan thereafter, Members are required to disclose to the Plan whether they have health coverage under any other certificate or policy. Members must also immediately notify the Plan if there are any changes in such coverage. If a Member fails to provide such information when requested, or to notify the Plan upon any changes to the Member's other health coverage, the Plan may deny payment for individual claims.

Determination of Benefits means determining the amount that will be paid for Covered services.

Coordination of Benefits or COB means determining which plan or policy is responsible for paying Benefits for Covered services first (primary carrier) when a member has dual coverage. Benefit payments are coordinated between the two (2) carriers to provide 100% coverage whenever possible for services Covered in whole or in part under either plan, but not to pay in excess of 100% of the total amounts to which providers or Members are entitled.

3.04 COORDINATION

When a Member has coverage under a certificate or policy that does not contain a COB provision, that certificate or policy will pay first. This means benefits under the other coverage will be determined before the Benefits of your Plan under this Benefits Document.

After those Benefits are determined, the Plan's Benefits and the benefits of the other plan will be coordinated to provide 100% coverage whenever possible for services Covered in whole or in part under either plan. In no case will payment be more than the amounts to which providers or Members are entitled.
The Plan does not pay claims or coordinate Benefits for services that:

- Are not provided or Preauthorized, when necessary, by the Plan; or
- Are not a Benefit under this Plan.

3.05 ORDER OF BENEFITS DETERMINATION (WHICH POLICY WILL PAY FIRST)

When a Member has coverage under another policy or certificate that does have a COB provision, these rules apply:

1. The Benefits of the policy that covers the person as a subscriber (policy-holder) will be determined first. The Benefits that cover the person as a dependent will be determined second.
2. If two (2) policies cover a person as a dependent, the policy of the person whose birthday falls earlier in the calendar year will be considered primary, i.e. those benefits will be determined first.
3. If two (2) policies cover a person as a dependent and the birthdays of the two (2) policy-holders are identical, the policy that has Covered the person longer will be primary.
4. If the claim is for a dependent minor child of divorced or legally separated parents, payment of benefits will be determined as follows:
    a. If the parents of the minor child are divorced, and the divorce decree or court order places financial responsibility for medical or other health care expenses on one specific parent, the policy of that parent will be primary.
    b. If the parents of the child are legally separated or divorced, and the parent with custody has not remarried and a court order does not specify which parent is responsible for medical coverage, the policy that covers the child as a dependent of the custodial parent will be paid firs.
    c. If the parents are divorced and the custodial parent has remarried:
        i. The benefits of the custodial parent's policy will be paid before the benefits of the custodial step-parent.
        ii. The policy that covers the minor child as a dependent of the custodial parent's spouse will be paid before the benefits that cover the minor child as a dependent of

the non-custodial parent.

d. If paragraphs 1, 2, 3 or 4 do not establish the order in which benefits should be paid, the policy or certificate that has Covered the person longer will pay first; provided however, that the benefits of a policy of a person who is laid- off or retired will be secondary to any other policy covering the person as an active employee.

3.06 COB WITH MEDICARE

- The Plan will coordinate Benefits with Medicare based on the following:
-
- If an individual covered by Medicare is also eligible for Coverage under this Plan and declines the Plan Coverage, Medicare is primary and the Plan will not provide any Coverage.
- If a Member is 65 years of age or older and has Coverage under this Plan based on current employment status (or based on current employment status of a spouse of any age), the Plan is the primary payer and Medicare is secondary.
- If a Member is 65 years of age or older and has Coverage under this Plan but is not in current employment status (e.g., the Member is Covered under COBRA), Medicare is primary. The Plan will pay all claims as if the Member is enrolled in Medicare, even if they have not yet enrolled.
- If a Member is entitled to Medicare coverage based on disability (and is less than 65 years of age) and has Coverage under this Plan based on the Member's (or the Member's spouse's) current employment status, the Plan is the primary payer and Medicare is secondary. If a Member is disabled and has Coverage under this Plan not based on the Member's (or the Member's spouse's) current employment status, then Medicare is the primary payer and this Plan is secondary.
- If a Member is eligible for or entitled to Medicare coverage based on End-Stage Renal Disease (ESRD) and has Coverage under this Plan: (a) for the first 30 months, the Member is eligible for or entitled to Medicare, the Plan is the primary payer and Medicare is secondary, and (b) after the first 30 months of Medicare eligibility or entitlement, Medicare is the primary payer and the Plan is secondary.
- It is your responsibility to apply for Medicare benefits that are available. If Medicare is primary, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

Should any federal law or regulations regarding the coordination of benefits between Medicare and group health plans change, or a new law or regulation is enacted regarding the same, the Plan shall be secondary to Medicare as permitted by the revised or new federal law or regulation despite any provision in this Benefits Document to the contrary.

3.07 COORDINATION OF BENEFITS (COB) EXCEPTION

Benefits under this Plan will not be reduced or otherwise limited because of a non-group contract that is issued as a hospital indemnity, surgical indemnity, specified disease, or other policy of disability insurance as defined in Section 3400 of the Insurance Code of 1956, Act No. 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.

3.08 COB ADMINISTRATION

If the Plan determines that Benefits under this Plan should have been reduced because of benefits available under another certificate or policy, the Plan has the right to:

- Recover any payments made to the Member directly from the Member; or
- Assess a reasonable charge for services provided by the Plan in excess of the Plan's liability.

If Benefits that should have been paid by the Plan have been provided under another certificate or policy, the Plan may directly reimburse whoever provided the Benefit payments.

For COB purposes, the Plan may release claims or obtain any necessary information from any insurance company or other organization. Any Member who claims Benefit payments under this Plan must furnish the Plan with any necessary information or authorization to do this.

3.09 SUBROGATION

Subrogation means that the Plan has the same right as a Member to recover expenses for services for which another person or organization is legally liable, to the extent that the Plan has provided or paid for the services. The Plan will be subrogated to the Member's right of recovery against the liable party.

- When you accept the Plan ID card, you agree that, as a condition of receiving Benefits and services under this Plan, you will make every effort to recover funds from the liable party. If you recover any funds for Benefits paid by the Plan, you will reimburse the Plan. The Plan shall have a lien against any such recoveries of funds whether by judgment, settlement, compromise or reimbursement. This applies no matter how the recovered funds are designed, i.e., economic or non-economic damages.
- When you accept the Plan ID card, it is understood that you acknowledge the Plan's right of subrogation. If the Plan requests, you will authorize this action through a subrogation agreement. If a subrogation lawsuit by you or by the Plan results in a financial recovery greater than the services and Benefits provided by the Plan, the Plan has the right to recover its legal fees and costs out of the excess.
- By accepting Benefits from the Plan, you and your covered dependents assign to the Plan any rights you or they may have to recover all or part of the same covered expenses from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses the Plan has paid on behalf of you and/or your covered dependents. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage. By virtue of the assignment, the Plan is entitled to recover 100 percent of the covered expenses it has paid on behalf of you or your covered dependents from all recoveries from a third party (whether by lawsuit, settlement or otherwise). This assignment allows the Plan to pursue any claim that you may have against a third party, or its insurer, whether or not you choose to pursue that claim.
- This assignment entitles the Plan to be reimbursed on a first-dollar basis (that means the Plan will have a first priority claim to the recovered funds), whether the funds paid to or for the benefit of you and/or your covered dependents amounts to a full or partial recovery, or whether the funds paid are designated for non-medical charges, attorney fees, pain and suffering, or other costs and expenses. The Plan's share of the recovery will not be reduced because you or your covered dependent has not received the full damages claimed, unless

the Plan agrees in writing to a reduction.

- The Plan has an equitable lien against any money or property you or your Covered Dependents recover from any party, including an insurer, another group health plan or individual, but only to the extent of the covered expenses that the Plan has paid.
- This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA and relevant case law. The Plan's provisions concerning subrogation, equitable liens, and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.
- You or your representative will do whatever is necessary to enable the Plan to implement the provisions of this Section. If you hire a lawyer to pursue a claim, you must inform the lawyer of the Plan's rights under this Plan. When reasonable collection costs and legal expenses are incurred in recovering amounts that benefit both you and the Plan, the costs and legal expenses will be divided equitably.
- You agree not to compromise or settle a claim or take any action that would prejudice the rights and interests of the Plan without getting the Plan's prior written consent.
- If you spend or otherwise allocate the proceeds recovered from a third party, the Plan reserves the right to recover the funds from your other assets if needed.
- If you refuse or do not cooperate with the Plan regarding subrogation, it will be grounds for terminating Membership in the Plan or the reduction of future benefits under the Plan by an amount up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

PART 4: RESCISSION OF COVERAGE

4.01 RESCISSION OF MEMBER'S COVERAGE

Rescission of Coverage means the Member's Coverage ends retroactive to the date a Member committed fraud against the Plan or a provider of Benefits, or intentionally misstated or intentionally withheld a material fact. We will provide at least 30 days' notice of a rescission. A Member may appeal a rescission of Coverage by following the Plan Complaint/Grievance and Appeals Procedure. Fraud or intentional misstatement or withholding of a material fact includes:

- Intentional misrepresentation of the eligibility of a Member;
- Fraudulent use of the Plan ID card; or
- Fraudulent use of the Plan system.

NOTE: Any amounts paid by the Plan after such event are due and owing from the Member. The Plan will recover any overpayments from the Member.

4.02 EFFECT OF RESCISSION

If Coverage or is rescinded by the Plan, the Subscriber or the affected Member(s) will no longer have Coverage under the Plan as of the effective date of rescission specified by the Plan. If a Member disagrees with a decision to rescind the Member's Coverage, the Member may appeal the decision following the Plan Member Complaint/Grievance and Appeals Procedure. Members will have Coverage under the Plan until the effective date of rescission. Under certain circumstances, a

Member who loses Coverage under this Plan may be eligible to enroll in an individual plan.

PART 5: CONTINUATION COVERAGE

5.01 COBRA COVERAGE

COBRA is the continuation of group health coverage, but at the Member's expense, for Members who lose eligibility for this Plan. Most Groups with over 20 employees are required by federal law to offer this opportunity. If you or your Covered Dependent's enrollment in this Plan would otherwise end you may be eligible for COBRA coverage. Contact your Human Resources representative for further information.

5.02 INDIVIDUAL (NON-GROUP) COVERAGE

If you or your Covered Dependent's enrollment in this Plan would otherwise end you may also be eligible for coverage under a non-group individual plan, including plans offered on the Michigan Marketplace. For further information, visit www.HealthCare.gov.

PART 6: GENERAL PROVISIONS

6.01 CHANGE OF ADDRESS

The Subscriber or Member must notify the Corporate HR Services – Benefit Department immediately of any change of Member's address.

6.02 HEADINGS

The titles and headings in this Benefits Document are intended only to make your Benefits Document easier to read and understand.

6.03 AGREEMENT WITH TERMS AND CONDITIONS

By using the Plan Coverage, you are agreeing to all terms, conditions and provisions of Coverage.

6.04 ASSIGNMENT

To the extent permitted by law, and except as specified under the terms of the Plan, no rights or benefits under the Plan will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. Rights under the Plan that cannot be assigned include, but are not limited to, your right to the services provided, the right to collect from the Plan for those services, the right to receive Plan documents and disclosures, the right to appeal Benefits or claims determinations (except that you may designate an authorized representative to act on your behalf with respect to claims and appeals) or the right to sue to enforce any such rights. Benefits under the Plan may be subject to a Qualified Medical Child Support Order. Coverage under the Plan is non-assignable and non- transferable.

6.05 PLAN POLICIES

The Plan may adopt reasonable policies, procedures, rules, and interpretations in order to administer Coverage.

6.06 MEDICAL BENEFITS DOCUMENT

Your Plan Medical Benefits Document consists of all of the following:

- This booklet;
- The Schedule of Member Cost Sharing;
- Any subsequent riders or amendments;
- The enrollment application;
- The McLaren Health Advantage identification card; and
- The Summary Plan Description – General Provisions.

6.07 WAIVER BY AGENTS

No agent or any other person, except an executive officer of the Plan, has the authority to do any of the following:

- Waive any conditions or restrictions of the Benefits Document;
- Extend the time for making payment; or
- Bind the Plan by making promises or representations or by giving or receiving any information.

6.08 AMENDMENTS

This Benefits Document is subject to amendment, modification, or termination. Such changes must be made in accordance with the terms of the Plan.

6.09 MAJOR DISASTERS

In the event of major disaster, epidemic or other circumstances beyond the control of the Plan, the Plan will attempt to perform its responsibilities under this Benefits Document insofar as it is practical, according to the Plan's best judgment and within any limitations of facilities and personnel that exist.

To the extent facilities and personnel are not available, causing delay or lack of services, there is no liability or obligation to perform affected responsibilities.

Such circumstances include, but are not limited to:

- Complete or partial disruption of facilities;
- Disability of a significant part of a facility or Plan personnel;
- War;
- Riot;
- Civil insurrection; or
- Labor disputes not within the control of the Plan.

6.10 CLERICAL ERRORS

Clerical errors, such as an incorrect transcription of effective dates, termination dates, or mailings with incorrect information will not change the rights or obligations of you and the Plan under this Benefits Document. These errors will not operate to grant additional benefits, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

6.11 WAIVER

In the event that you or the Plan waive any provision of this Benefits Document, you or the Plan will not be considered to have waived that provision at any other time or to have waived any other provision. Failure to exercise any right under this Benefits Document does not act as a waiver of that right.

PART 7: YOUR BENEFITS

The Plan will provide Benefits in accordance with the requirements of all applicable laws. Our comprehensive Plan provides Coverage for a wide array of hospital and physician services. These Benefits are described in the following pages and in the Schedule of Member Cost Sharing that is applicable to the Health Benefit Option you have chosen for the Plan Year.

7.01 BENEFIT COVERAGE LEVELS:

Your Benefits and Member Out-of-Pocket Expenses (i.e., Copayments, Coinsurance, Deductible and Balance Bills) are based upon the Health Benefit Option you choose, and which Network of Providers you use. The Health Benefit Options are available upon request from the Corporate HR Services – Benefit Department.

7.01.01 PROVIDERS AND PROVIDER NETWORKS

Tier 1 Providers: When you receive services from Tier 1 Providers and obtain any necessary Preauthorization from the Plan, your health care is provided at the lowest Out-of-Pocket Expense to you. Tier 1 Providers are (1) McLaren owned or employed providers; and (2) certain providers directly contracted with McLaren Health Advantage and listed in the Tier 1 Provider Directory.

Tier 2 Providers: When you receive services from Tier 2 Providers and obtain any necessary Preauthorization from the Plan, your health care is provided at a greater Out-of-Pocket Expense to you. Tier 2 Providers are providers directly contracted with McLaren Health Advantage and listed in the Tier 2 Provider Directory.

Out-of-Network Providers: When you receive services from an Out-of-Network Provider your health care is provided with higher Out-of-Pocket Expenses to you. Out-of-Network Providers are providers who are not Tier 1 Providers or Tier 2 Providers. **Note:** If you choose to receive services from an Out-of-Network Provider, and the services are not subject to Applicable Surprise Billing Laws, in addition to higher Out-of-Pocket Expenses you may also be responsible to pay the "**Balance Bill**", which is the price difference between the cost of the services (the provider's actual charge) and the amount the Plan pays for that service (the Reimbursement Amount). These costs can be significant,

so it is important to understand your liability when using an Out-of-Network Provider.

Secondary Network Providers: Secondary Network Providers include GlobalCare/Zelis Providers that have contracted directly with the Plan. Access to GlobalCare/Zelis is limited to the following:

- Urgent Care Services
- NICU
- High Risk OB delivery/inpatient admission
- Additionally, for McLaren St. Lukes covered Members only, claims that are preauthorized in advance because the requested services cannot be provided by Tier 1 Provider in Ohio, as provided in Section 7.03.02.

*If the Plan is unable to Calculate the Qualifying Payment Amount under Applicable Surprise Billing Laws, the Plan may, in its discretion, send a claim to Globalcare/Zelis for the following types of Covered Services:

- Emergency Services
- Emergency Air Ambulance Services
- Inpatient admissions through the Emergency Department

Contact Customer Service at (888) 327-0671 for more information about Secondary Network Providers.

A complete list of Tier 1 Providers and Tier 2 Providers can be found in the Provider Directory at www.McLarenHealthPlan.org. Any other provider not listed in the Directory is also an Out-of-

Network Provider. You may call McLaren Health Advantage's Customer Service for assistance in choosing a provider. The contact number for Customer Service is (888) 327-0671.

7.01.02 TRANSITIONAL CARE

In limited circumstances, with Plan Preauthorization, a Member newly enrolled with the Plan may continue a course of treatment with a Tier 2 Provider or Out-of-Network Provider, and the Plan will Cover such services at the Tier 1 Provider Coverage level ("**Transitional Care**").
However, you may be subject to Balance Billing.

The Preauthorization of Transitional Care is subject to Plan medical review and medical documentation provided by the Member or the treating physician on behalf of the Member.
In general, if the Plan Preauthorizes Transitional Care, the period of time Preauthorized will be one (1) calendar year. Upon request for renewal of Transitional Care, the Plan will conduct a medical review based upon updated medical documentation provided by the Member.

7.01.03 CONTINUING CARE AS A RESULT OF TERMINATION OF A TIER 1 OR TIER 2 PROVIDER'S CONTRACT

Definitions:

Continuing Care Patient

"Continuing Care Patient" means an individual who, with respect to a Tier 1 Provider or Tier 2 Provider or a Tier 1 Provider Facility or Tier 2 Provider Facility:

- Is undergoing a course of treatment for a Serious and Complex Condition from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility;
- Is undergoing a course of institutional or Inpatient care from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility;
- Is scheduled to undergo nonelective surgery from the Tier 1 Provider or Tier 2 Provider, including receipt of postoperative care from such Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility with respect to such surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility or;
- Is or was determined to be terminally ill and is receiving treatment for such illness from such Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility.

"Serious and Complex Condition" means, with respect to the Member:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Process:

A Tier 1 Provider or Tier 2 Provider may choose to terminate his/her contract or arrangement with McLaren Health Advantage. Therefore, we cannot guarantee that a given Tier 1 Provider or Tier 2 Provider will be available to treat a Member during the entire time the Member is Covered by the Plan. If Tier 1 Provider or Tier 2 Provider informs a Member that the Provider will no longer be a contracted Provider, the Member should contact Customer Service at (at 1-888- 327-0671) as soon as possible.

If a Tier 1 Provider or Tier 2 Provider's contract or arrangement with McLaren Health Advantage is terminated, a Member receiving services from the terminating Provider may wish to select a different Tier 1 Provider or Tier 2 Provider in order to continue receiving Covered Services with lower Out-of-Pocket Expenses. However, a Tier 1 Provider will have the lowest Out-of-Pocket Expenses. However, a Member who is undergoing an ongoing course of treatment with the terminating a Tier 1 Provider or Tier 2 Provider may be eligible to continue to be treated by this Provider if:

- The treatment is for a Serious and Complex Condition, in-patient care, a scheduled nonelective surgery, pregnancy, or Terminal Illness;
- The continuation period is approved by the Plan;
- The Provider is still available to continue treating Members;
- The Provider agrees to continue to meet McLaren Health Advantage's quality standards and comply with McLaren Health Advantage policies and procedures;
- The Provider is not leaving the network due to a failure to meet the McLaren Health Advantage's quality standards or because of fraudulent conduct; and
- The Provider agrees to accept McLaren Health Advantage's payment as payment in full at the rates applicable prior to the Provider's termination, not including applicable Member Copayments, Coinsurance or Deductible.

This continuation of treatment with the Provider may be continued, as applicable:

- For up to 90 days after the Member receives notice from MHA that the Provider is leaving the Provider network;
- Through the second and third trimester of a pregnancy (in the case of a pregnant woman) and through the completion of post-partum care; or
- In the case of a Member with a Terminal Illness, through the remainder of the Member's life for treatment related to the Terminal Illness if the Member was diagnosed as Terminally Ill prior to receiving notification of the Provider's termination.

To the extent not covered here, we will provide continuity of care as required by applicable federal law. Notwithstanding anything to the contrary in this Section, the Plan complies with applicable requirements in 42 USC 300gg-113 related to continuity of care. Specifically, if a Tier 1 Provider or Tier 2 Provider contract is "terminated", as defined in 24 USC 300gg-113(b)(3), or if benefits under this Benefits Document with respect to the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider or Tier 2 Facility are terminated because of a change in the terms of the participation of the Tier 1 Provider or Tier 2 Provider or Tier 1 Provider Facility or Tier 2 Provider Facility in the plan or coverage or if the contract between the Group and McLaren Health Advantage is terminated, resulting in a loss of benefits provided under the plan with respect to a Provider or Facility, the Plan will:

- Notify Members who are Continuing Care Patients of the termination and of their right to elect transitional care from a Tier 1 Provider or Tier 2 Provider,
- Provide eligible Members the opportunity to notify us of the need for transitional care, and
- Permit Members to elect to continue benefits under the same terms and conditions that would have applied until the earlier of 90 days after notice provided by the Plan to the Member or the date Member is no longer a Continuing Care Patient

7.02 COPAYMENTS, COINSURANCE AND DEDUCTIBLES

You are responsible for Copayments, Coinsurance or Deductibles for many of the Benefits listed. Copayments, Coinsurance or Deductibles may apply to physician, inpatient and outpatient services. The Copayment, Coinsurance and Deductible amounts are listed in your Schedule of Member Cost Sharing.

7.03 PREAUTHORIZATION

7.03.01 PREAUTHORIZATION FOR COVERED SERVICES

Certain services and supplies require Preauthorization by the Plan before they will be Covered. Excluding Emergency Services, this is true whether they are received from a Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider. The Sections of this Benefits Document that describe particular Covered Services include Preauthorization requirements. Providers will assist you in obtaining Preauthorization from the Plan, but the Member is ultimately responsible to ensure any necessary Preauthorization is obtained before the Member receives the service. If the Plan Preauthorizes a service, we will notify the provider who will be providing the service.

The complete and detailed list of services requiring Preauthorization is available by calling our Customer Service Department or visiting our website at www.McLarenHealthPlan.org. The list may change throughout the Plan Year as new technology and standards of care emerge. Below are the general categories of services and supplies that require Preauthorization by the Plan:

- Inpatient and long term acute Hospital services, including inpatient mental health or substance abuse treatment and inpatient rehabilitation;
- Skilled nursing home;
- Outpatient Hospital and clinic services;
- Oral surgery, TMJ treatments and orthognathic surgery;
- Special surgical procedures;
- Durable medical equipment (DME) costing more than an amount designated in the Schedule of Member Cost Sharing;
- Prosthetics, orthotics and corrective appliances costing more than an amount designated in the Schedule of Member Cost Sharing;
- Insulin pumps and continuous glucose monitors;
- Genetic testing (including BRCA testing Covered under Section 7.04);
- Home health care;
- Hospice care;
- Residential Mental Health Treatment;
- Residential Substance Abuse Treatment;
- Partial Treatment Programs for Mental Health Treatment;
- Partial Hospitalization for Substance Abuse Treatment;
- Electroconvulsive therapy;
- Organ and tissue transplants;
- Injectable and infusion medications provided in the office setting or in an infusion center;
- Gender reassignment surgery;
- Certain Prescription Drugs (refer to the Plan Formulary at www.McLarenHealthPlan.org);
- Proton Beam Therapy;
- Gene Therapy - Cellular and Gene therapy, intended to restore defective or insufficient structural or functional proteins by inactivating, introducing, or replacing a modified or new gene (treatment is limited to once per lifetime regardless of insurance coverage at the time of initial treatment;)

7.03.02 PREAUTHORIZATION FOR TIER 2 PROVIDER OR OUT-OF-NETWORK SERVICES TO BE COVERED AT TIER 1 PROVIDER LEVEL

In certain limited circumstances, the Plan may cover Services provided by an Out-of-Network Provider or Tier 2 Provider at the Tier 1 Provider Cost-Sharing. Excluding Emergency Services, this is limited to the following circumstances:

- Hospital to hospital transfers (e.g., an In-Network Hospital transfers a Member to an Out-of-Network Hospital when services cannot be provided In-Network)
- Services are not available from a Tier 1 Provider
- Tier 1 Provider Laboratory sends labs to a Tier 2 Provider Laboratory or Out-of-Network Laboratory because they cannot perform the requested service

Note – Transitional Care may also be Covered at the Tier 1 Cost Sharing (See Section 7.01.02 for details and how to request a pre-authorization).

Members may request the Plan to Preauthorize Coverage of Out-of-Network or Tier 2 Provider services at the Tier 1 Benefit level. If you or your provider believes that Service meets the above listed circumstances, you must request a Preauthorization for Tier 1 Provider Coverage **prior to receiving services**. You or your provider must specifically ask for the services to be covered at the Tier 1 Provider Cost Sharing. A general request for Preauthorization is insufficient. The services will not be Covered under the Tier 1 Provider Cost Sharing if you do not request a Preauthorization in advance. Notwithstanding the foregoing, Members can request a retro review if a Tier 1 Laboratory sends labs to a Tier 2 or Out-of-Network Laboratory because they cannot perform the requested service.

When the Plan receives your Preauthorization request, the Plan will review the clinical indications and factors of the case, and will determine whether the services are available from a

Tier 1 Provider. Note – location of a Tier 1 Provider (e.g., driving distance) is not a factor that will be considered. If the Plan determines that the services are not available from a Tier 1 Provider, the Plan will direct the Member to the provider deemed to be the most appropriate to address the Member's medical needs. The Plan's decision with respect to the request will be communicated to the Member in writing. NOTE - You may be subject to Balance Billing.
If the Plan determines that the requested services can be provided by a Tier 1 Provider, services obtained from a Tier 2 or Out-of-Network Provider will not be Covered at the Tier 1 Level; they will be Covered at the applicable Tier 2 or Out-of-Network Benefit Level.

7.03.03 TIMING OF REQUEST FOR PREAUTHORIZATION AND PLAN RESPONSE

Definition: Urgent Preauthorization Request means a request for medical care or treatment for which resolution within the Plan's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of the Member or the ability to regain maximum function, or, in the opinion of the treating Provider, would subject the Member to severe pain that could not be adequately managed without the requested service.

For most non-Urgent Preauthorization Requests, the Plan or its designee will make a decision within 15 calendar days after receiving the request. For Urgent Preauthorization Requests, the Plan or its designee will make a decision as expeditiously as possible considering the medical condition of the Member, but no later than within 72 hours after receiving the request. The Plan may extend the 72 hour maximum response time if the Member fails to provide the Plan with necessary information.

Denial of Request for Preauthorization: If a Member disagrees with a decision regarding a Preauthorization request, the Member or his/her treating practitioner or designee may contact the Plan to request a re-evaluation of the decision or utilize the appeal process described in Section 1.04.01, "*Regular Internal Appeals*".

A Member may request an expedited appeal for denials of Urgent Preauthorization Requests. See Section 1.04.02, "*Expedited Complaint/Grievance and Appeals***".**

7.04 PREVENTIVE SERVICES

Preventive Services are screenings, immunizations, lab tests and other services that are required to be provided in the federal Patient Protection and Affordable Care Act to help prevent illness or help finding diseases or medical conditions before you experience symptoms. Some services are Preventive Services only for specified age groups or genders.

Preventive Services are Covered in full with no Deductible, Coinsurance or Copayment when provided by any Tier 1 Provider.

Note: There is no Coverage for Preventive Services provided by a Tier 2 or Out-of-Network Provider unless the service cannot be provided by a Tier 1 Provider.

The list of Preventive Services is updated by the U.S. Preventive Services Task Force on a regular basis. Therefore, the information below may change. Where there is an update to a recommendation, coverage will be provided for the Plan Year beginning on or after one year after the date the recommendation is issued. If you have a question as to whether a service is considered Preventive please contact Customer Service at (888) 327-0671. You may also visit the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and- b-recommendations/ or www.HealthCare.gov.

If a recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of a recommended Preventive Service, the Plan may use reasonable medical management techniques to determine any such coverage limitations. For more information specific to contraceptives, see the "Note" below under Preventive Services for Women.

The following are the general categories of Preventive Services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

The following are services that are currently Covered as Preventive Services:

Physical Exams

Routine well child visits including physical and developmental screenings and assessments for all children in accordance with the recommendations for Preventive Pediatric Health Care issues by Bright Futures/American Academy of Pediatrics.

Immunizations

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

- Certain vaccines for children from birth to age 18
- Certain vaccines for all adults

Assessments and screenings newborn to age 21

Recommended ages and who should have these services vary, and include but are not limited to:

- Developmental screening
- Hearing loss screening
- Vision screening
- HIV screening for adolescents
- Sexually transmitted infection screening for sexually active adolescents
- Depression screening for adolescents
- Screening and counseling for obesity

Preventive services for women

Service	Who	Frequency
Obesity prevention in midlife women	Women age 40 to 60 with normal or overweight body mass index	As needed
Well-woman visits (includes pre- pregnancy, prenatal, postpartum and interpregnancy visits)	Adult women	Annually and/or as needed
Gestational diabetes screening	Women 24-28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
Breast Cancer Screening (mammography only)	Women aged 40 to at least age 74	Annually or every 2 years
Cervical Cancer Screening (Pap test)	Women aged 21 to 30 years	Every 3 years
Cervical Cancer Screen (Pap test and Co-Testing for (HPV))	Women aged 30 to 65 years	Every 3 years for Pap Test alone or Co-testing for HPV every 5 years
Sexually transmitted infection (STI) counseling	Sexually-active women	Annually
HIV screening and counseling	Women aged 15 and older Sexually-active women	At least once during their lifetime Annually, or as appropriate

Risk Assessment and Prevention Education for HIV infection	Women aged 13 and older	As needed
Contraceptive methods*, sterilization procedures and patient education and counseling (including instruction in fertility awareness-based methods, including lactation amenorrhea)	Sexually-active women	As needed
Breastfeeding support, supplies (including a double electric breast pump and breast milk storage supplies) and	Pregnant and postpartum women	Per pregnancy
counseling**		
Interpersonal and domestic violence screening and counseling	All adolescent and adult women	At least annually and as needed

***Note**: "Contraceptive methods" include Coverage for Preferred Generic and Preferred Brand Name contraceptive medications, devices and appliances when prescribed by a provider and obtained through a Preferred Pharmacy or, as applicable, a Tier 1 Provider. Over-the-counter contraceptives are also Covered, provided you obtain a prescription from your provider and obtain the contraceptive at a Preferred Pharmacy. Additional terms and conditions of Coverage for contraceptive medications, devices and appliances are found in Section 7.31, Prescription Drug Coverage. Some devices and appliances (e.g., IUD's) are Covered under your medical Benefits and are subject to the medical conditions of Coverage. Please contact Customer Service at (888) 327-0671 for additional information.

- The Plan also covers, without cost sharing, contraceptive services and FDA approved, cleared, or granted contraceptive products that your attending provider, who is a Tier 1 Provider, and has determined to be medically appropriate for you, even if the contraceptives are not in the categories listed in the then applicable HRSA-Supported Guidelines ("HRSA Guidelines"). This can include contraceptive products more recently approved, cleared, or granted by FDA. Contraceptives must be prescribed and administered by a Tier 1 Provider. When obtained through the pharmacy benefit, contraceptives must be ordered by a Tier 1 Provider and delivered through an In- Network Pharmacy.
- Coverage for contraceptives is subject to reasonable medical management techniques.
  - *HRSA Guidelines* – The Plan covers at least one contraceptive in each HRSA Guidelines category at no cost sharing. See your Formulary for Covered contraceptives within the HRSA Guidelines.
  - *Outside HRSA Guidelines* - For contraceptives not included in the HRSA Guidelines, the Plan will use reasonable medical management techniques to determine which products to cover without cost sharing, when multiple, substantially similar services or products that are not included in a category in the HRSA Guidelines are available and are medically appropriate for you.

- If your Tier 1 Provider determines a contraceptive not listed in the Plan's Formulary is medically necessary (regardless of whether it is in the HRSA Guidelines), you or your Tier 1 Provider may submit an exception to the Plan in accordance with the Plan's exceptions process. The Plan's exceptions process is easily accessible, transparent and when appropriate, expeditious. Please contact Customer Service at (888) 327-0671 for more information on the exception process.
- To the extent required by law, the Plan will defer to the determination of your attending provider, who is an In-Network Provider, that coverage is medically necessary, so you can obtain Coverage for the medically necessary contraceptive service or product without cost sharing.

** **Note:** A list of Tier 1 lactation consultants can be found in the Provider Directory at www.McLarenHealthPlan.org.

Assessments and screenings for adults

Recommended ages and who should have these services vary, and include but are not limited to:

- Blood pressure screening
- Breast cancer screening, mammography and prevention (BRCA genetic testing requires Preauthorization)
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Alcohol misuse screening
- Medical history
- HIV screening
- Certain sexually transmitted infection (STI) screening
- Sexually transmitted infection (STI) prevention counseling for high risk adults
- Screening and counseling for obesity
- Screening for tobacco use
- Counseling regarding use of aspirin to prevent cardiovascular disease
- Diet counseling – adults at higher risk for chronic disease

Additional assessments and screenings for adult pregnant women include but are not limited to:

- Screening for bacteriuria
- Screening for hepatitis B
- Screening for RH incompatibility
- Screening for syphilis

Tobacco Use Counseling and Interventions for Adults

These services include:

- Screening for tobacco use.
- Tobacco cessation Prescription Drugs for 90 days per quit attempt (limited to two (2) quit attempts per year), when prescribed by your Provider and obtained at a Preferred Pharmacy. (See Section 7.31, Prescription Drug Coverage.)

Drugs other than contraceptive or tobacco cessation medications (prescription required):

Recommended ages and who should have these services vary and include, but are not limited to:

- Oral fluoride supplements
- Folic acid supplements
- Iron supplements

Refer to Section 7.31, Prescription Drug Coverage, for Coverage information.

General Limitations:

Members should note that preventive screenings received more than once a Plan year and/or received before or after the age indicated are not considered Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services. With some limited exceptions (e.g., a post-procedure biopsy on a polyps located as part of a Preventive colonoscopy), services that are performed for diagnostic purposes (as opposed to screening purposes) are likewise not Preventive Services, and the Member will be responsible for paying any applicable Copayment, Coinsurance or Deductible for such services.

Exclusions:

Preventive Services are not Covered when provided by a Tier 2 Provider or Out-of-Network Provider, unless the service cannot be provided by any Tier 1 Provider.

7.05 DIABETIC SERVICES

The following equipment, supplies, drugs and educational training related to the treatment of diabetes are Covered if determined to be Medically Necessary and prescribed by the Member's treating Provider:

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Test strips for glucose monitors, visual reading and urine reading strips, lancets and spring-powered lancet devices;
- Insulin pumps and medical supplies required for the use of an insulin pump*;
- Insulin syringes;
- Insulin**;
- Non-experimental medication for controlling blood sugar**;
- Medications used in the treatment of foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes if prescribed by an allopathic, osteopathic or podiatric physician**; and
- Diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management and treatment of their condition.

*** Note**: Insulin pumps and continuous glucose monitors require Preauthorization.

**Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a Provider for DME. Your DME Cost Sharing will apply. These supplies may also be purchased at an In-Network pharmacy and your Prescription Drug Cost Sharing will apply.

**Your Prescription Drug Cost Sharing will apply for Covered Prescription drugs.

Limitations:

Coverage for diabetes self-management training is available if the following conditions apply:

- It is limited to completion of a certified diabetes education program if:
  - Considered Medically Necessary upon the diagnosis of diabetes by the Provider who is managing the Member's diabetic condition and if the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
  - The Member's treating Provider diagnoses a significant change with long-term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.

- It is provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Health and Human Services (MDHHS). This training shall be conducted in group settings whenever available.

7.06 PROFESSIONAL PHYSICIAN SERVICES (OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE)

The following services are Covered when they are Medically Necessary and, as necessary, Preauthorized by the Plan. **Note:** These services are also Covered when provided by other practitioners (nurses, nurse practitioners or physicians' assistants) when such services are within their licensed scope of practice.

7.06.01 PHYSICIAN OFFICE VISITS

Includes:

- Allergy test and serum
- Allergy injections
- Hearing exams
- Diabetes education (see Section 7.05)
- Home visits
- Emergency Care
- Consultations
- OB/GYN services

Note: If you receive a Covered physician office visit in an Inpatient or Outpatient Facility setting, the Inpatient or Outpatient Cost Sharing, as applicable, will apply (not the Primary Care Physician (PCP) Office Visit or Specialist Office Visit Cost-Sharing).

7.06.02 IMMUNIZATIONS

Covered Services:

Immunizations that are included as Preventive Services are Covered pursuant to Section 7.04. All other Medically Necessary immunizations are Covered under this Section.

7.06.03 MATERNITY CARE AND NEWBORN CARE – INCLUDING PRENATAL AND POSTNATAL VISITS

Covered Services:

- Hospital and physician care:
  - Services and supplies furnished by a Hospital or other Provider for prenatal care, including genetic testing, postnatal care, Hospital delivery and care for the complications of pregnancy are Covered.
  - Services provided by a certified nurse midwife and within the scope of practice of the certified nurse midwife are Covered, including:
    - Prenatal and postnatal care
    - Normal vaginal delivery when provided in an inpatient hospital setting or a birthing center that is hospital-affiliated, state licensed and accredited as defined and approved by the Plan.

Note: Preauthorization is not required for the minimum hospital stay described below. Hospital length of stay begins at the time of delivery, if the delivery occurs in a Hospital and at the time of admission in connection with childbirth if the delivery occurs outside the Hospital.

Minimum Hospital Stay: The mother and Newborn have the right to an inpatient stay of no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If the mother and her attending physician agree, the mother and the Newborn may be discharged from the Hospital sooner.

- Newborn child care: Inpatient medical or Hospital services for a healthy newborn following delivery are Covered as a part of the Member mother's Coverage through the date of discharge of the Member mother or the newborn, whichever first occurs. If you want the newborn's Coverage to continue beyond such discharge, you must add the child to your Coverage within 31 days after the child is born.

Limitations and Exclusions:

- Genetic testing requires Preauthorization.
- All maternity care, including prenatal services, delivery services and postpartum care, provided by a Tier 2 Provider or Out-of-Network Provider will have higher Member Cost Sharing, even if the care is provided while traveling outside of the State. A routine delivery will not be Covered as a Medical Emergency.
- Services and supplies received in connection with an obstetrical delivery in the home or free-standing birthing center are not Covered.

7.06.04 INJECTABLE DRUGS PROVIDED IN THE OFFICE

Certain medications that are injected or infused in the provider's office or in an infusion center require Preauthorization and are Covered under the Member's medical benefit. Examples include, but are not limited to: injections/infusions for treatment of chronic diseases such as multiple sclerosis, osteoporosis, rheumatoid arthritis and colitis.

7.07 SPINAL TREATMENT

Covered Services:

- Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects.
- Other services related to treatment, including diagnosis and x-rays.

Limitations:

- The interference, as stated above, must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
- Treatment must be provided by a Spinal Treatment provider in the provider's office.
- Spinal Treatment benefits are limited to one (1) visit and treatment per day.
- This Benefit is limited to twenty-four (24) visits per year.

7.08 EMERGENCY AND URGENT CARE

Definitions

Medical Emergency – The sudden onset of a medical condition that manifests itself by signs and acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to your health or to your pregnancy, in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Accidental Injury – A traumatic injury, which if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.

Emergency Services – Services to treat emergency conditions as described above.

Stabilization – The point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during your transfer.

Urgent Care or Urgent Care Center – Care provided at an Urgent Care Center instead of a Hospital emergency room, when you need immediate care to treat a non-life threatening illness or injury to limit severity and prevent complications.

Coverage

- Services for a **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered up to the point of stabilization when they are Medically Necessary and needed immediately to treat a medical emergency as defined above. Preauthorization is not required.

- Services for **medical emergency or accidental injury**, including mental health or substance abuse-related medical emergencies, are Covered when provided by a Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider. **Note, however:** Unless an Applicable Surprise Billing Law applies, when services are provided by an Out-of- Network Provider, the Member may be responsible for any Balance Bill (the difference between the amount paid by the Plan and the amount of the Out-of-Network Provider's charges). Your applicable cost sharing (Copayment, Coinsurance, or Deductible) will apply even if you are directed or otherwise referred to the emergency room by your physician.

- Services for treatment of an illness or injury that needs immediate attention, such as cuts or sprains, that is not as serious as a medical emergency, are Covered under **urgent care**.

Limitations:

- In case of such a **medical emergency or accidental injury**, you should seek treatment at once. We urge you, the hospital, or someone acting for you to notify the Plan within 24 hours, or as soon as medically reasonable.

- **Emergency services** are no longer payable as emergency services at the point of the patient's Stabilization as defined above.

7.09 AMBULANCE

An ambulance is a vehicle specially equipped and licensed for transporting injured or sick persons. Emergency ground and air ambulance services that meet the requirements described below do not require Preauthorization. Non-emergency ground ambulance services require Preauthorization.

Coverage

The following ambulance services are Covered:

- Non-emergency Medically Necessary ground ambulance services to transport a Member from one facility to another.
  - Emergency ground ambulance services when:
  - You are admitted as an inpatient to the hospital immediately following emergency room treatment.
  - The services are necessary for management of shock, unconsciousness, heart attack or other condition requiring active medical management.
  - The services are needed for emergency delivery and care of a Newborn and mother. See Exclusions below.

- The ambulance is ordered by another person or entity, and you are not in a position to refuse (e.g., by an employer, school, fire, public safety official, hospital representative for transfer to another hospital).
- Air ambulance for emergency transport is Covered to the nearest hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and the additional requirements for a ground ambulance Coverage and must be verified by the records of the physician who treats you and by the ambulance company.

Exclusions:

- Ambulance services for normal or false labor are not Covered.
- Ground ambulance services that are not Medically Necessary are not Covered.
- Transportation and/or medical services provided by public first responders to accidents, injuries or emergency situations including fire or police departments costs, or any associated services provided as part of a response to an accident or emergency situation, like accident clean-up or 911 costs are not a covered Benefit. This is because these services are part of public programs supported totally or in part by federal, state or local governmental funds.
- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.
- Air ambulance services must be provided by a licensed air ambulance company and not a commercial or private airline.
- Air ambulance services that are non-emergent

7.10 INPATIENT AND LONG-TERM ACUTE HOSPITAL SERVICES

The following Hospital and long-term acute inpatient services are Covered when Medically Necessary and when the inpatient admission has been Preauthorized by the Plan:

- Semi-private room and board, general nursing services, and special diets**;**
- Operating and other surgical treatment rooms, delivery rooms, and special care units;
- Surgery;
- Professional services, including surgical services;
- Anesthesia, laboratory, radiology and pathology services;
- Chemotherapy, inhalation therapy and hemodialysis;
- Infusion therapy;
- Physical, speech and occupational therapies;
- Other inpatient services and supplies necessary for the treatment of the Member;
- Maternity care and routine nursery care of Newborn (see Sections 7.06.03 – “Maternity Care and Newborn Care” and 8.12 for limitations); and
- Non-emergency transport between facilities.

Exclusions:

- Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass

during an inpatient stay.
- Sleep studies. Sleep studies must be performed in the outpatient setting.

7.11 OUTPATIENT SERVICES

Covered Services:

Facility and professional (physician) therapeutic and non-preventive diagnostic laboratory, pathology and radiology services and other procedures when performed in an Tier 1 Provider, Tier 2 Provider or Out-of-Network Provider setting, including outpatient Hospital setting, physician office, free standing center, or dialysis center for the diagnosis or treatment of a disease, injury or other medical condition when Medically Necessary and, where required, Preauthorized by the Plan. See Section 7.03 for Preauthorization requirements. Outpatient Hospital services include the following:

- Outpatient surgery;
- Outpatient CT scans, PET scans, MRI and nuclear medicine;
- Outpatient procedures for treatment of breast cancer, including outpatient surgery, chemotherapy and radiation treatment;
- Outpatient hemodialysis;
- Professional Services including physician surgical services; also see Professional Physician Services section; and
- Outpatient infusion therapy.

7.12 DIAGNOSTIC AND THERAPEUTIC SERVICES AND TESTS

The Plan Covers Medically Necessary and, as applicable, Preauthorized therapeutic and diagnostic laboratory, pathology and radiology services, and other procedures for the diagnosis or treatment of a disease, injury or medical condition. See Section 7.03 for Preauthorization requirements.

Services and tests that are included as Preventive Services are Covered pursuant to Section 7.04. Please refer to the complete list of Preventive Services at www.McLarenHealthPlan.org or call Customer Service at (888) 327-0671. All other such services may be subject to Copayments, Coinsurance and/or Deductibles. Please refer to your Schedule of Member Cost Sharing.

Diagnostic and therapeutic services and tests include the following:
- Pathology services and laboratory tests; and
- Diagnostic procedures.

7.13 ORGAN AND TISSUE TRANSPLANTS

An organ or body tissue transplant is Covered when:

- It is Preauthorized by the Plan;
- It is considered non-experimental in accordance with generally accepted medical practice;
- It is Medically Necessary; and
- It is performed at a Plan approved facility.

Coverage is provided for related drugs for treatment of cancer pursuant to Section 7.30 of this Benefits Document.

For a Preauthorized transplant, the Plan also Covers:

- Up to a total of $5,000 for travel, meals and lodging expenses directly related to Preauthorized services.
- The expenses must be incurred during the period that begins with the date of Preauthorization and ends 180 days after the transplant.
- The expenses of an adult patient and another person, or expenses of a patient under the age of 18 years and expenses for two (2) additional people, will be Covered.
- The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:
  - Up to $60.00 per day for travel;
  - Up to $50 per day for lodging; and
  - Up to $40 per day for meals.
- Not subject to Deductible, Coinsurance or Copayment.
- The necessary Hospital, surgical, lab and x-ray services for a non-Member donor, unless the non-Member donor has coverage for such services.
- Hospitalization in an intensive care unit, special care unit or private room.

Exclusions:

- Services that are not Preauthorized
- Meals and lodging for donors

7.14 SPECIAL SURGICAL PROCEDURES

The Plan Covers surgical procedures that are Medically Necessary and are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, accidental injuries, tumors or disease. Coverage is also provided for correction of traumatic scars. In order for these services to be Covered, you must meet nationally recognized Medical Necessity criteria, and the Plan must Preauthorize the services.

7.14.01 MORBID OBESITY WEIGHT LOSS SURGERY

The Plan Covers surgery for morbid obesity weight loss surgery when it is Medically Necessary and Preauthorized by the Plan.

7.14.02 OTHER SPECIAL SURGICAL PROCEDURES

The Plan Covers the following additional surgeries when they are Medically Necessary and Preauthorized by the Plan.

- Reduction mammoplasty;
- Reconstructive services to correct physical impairments;
- Blepharoplasty of upper eyelids;

- Rhinoplasty;
- Septorhinoplasty;
- Panniculectomy;
- Surgical treatment of male gynecomastia; and
- Procedures to correct obstructive sleep apnea.

7.15 BREAST RECONSTRUCTION FOLLOWING A MASECTOMY

Coverage is available for breast reconstruction in connection with a mastectomy. Covered Benefits include:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthetics (see Section 7.22); and
- Care for physical complications from all stages of the mastectomy including lymphedemas.

7.16 SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility services are Covered when Medically Necessary for recovery from surgery, disease or injury.

Limitations:

- The services must be Preauthorized by the Plan to be Covered.
- The Plan Covers semi-private rooms. Private rooms are Covered only when Preauthorized by the Plan.

Exclusions:

- Custodial/basic care is not Covered.

7.17 HOME CARE SERVICES

Covered home care services include skilled nursing care, medical supplies and other health care services performed in the Member's home when prescribed by a physician and Medically Necessary.

Limitations:

- All services must be Preauthorized by the Plan

Exclusions:

- Rehabilitative Services. Rehabilitative Services provided in the home are subject to the Coverage provisions and limitations described in Sections 7.20 of this Benefit Document
- Housekeeping services
- Services that are primarily for the purpose of providing long-term custodial care

7.18 HOSPICE CARE

Coverage is for the Terminally Ill through a hospice program. Hospice care includes physical, psychological, social and spiritual care for the Terminally Ill person, and short-term grief counseling for immediate family members.

Patients using hospice services have their regular McLaren Health Advantage Benefits relating to their Terminal Illness replaced by the following:

- Home Care Services:
  - Up to eight hours of routine home care per day
  - Continuous home care for up to 24 hours per day during periods of crisis
  - Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse

- Facility Services:
  - Inpatient care provided by a
    - In-Network hospice inpatient unit
    - In-Network hospice contracting with the hospice program or
    - Skilled nursing facility contracting with the hospice program
  - Short-term general inpatient care when the Member is admitted for pain control or to manage symptoms. (These services are Covered if they meet the plan of care established for the Member.)
  - Five (5) non-sequential days of respite care during a 30-day period

Exclusions:

- Housekeeping services
- Financial or legal counseling
- These services are not Covered if primarily for the purpose of providing long-term custodial care.

7.19 MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

7.19.01 MENTAL HEALTH SERVICES

Definitions:

Inpatient Mental Health Service is the service provided during the time a Member is admitted to a Plan-approved acute care facility that provides continuous 24-hour nursing care for comprehensive treatment.

Outpatient Mental Health Services include individual, conjoint, family or group psychotherapy and crisis intervention.

Partial Treatment Program is a planned program of psychiatric services for the treatment of mental nervous disorders given in a Hospital or other licensed treatment facility on less than a full-time Inpatient basis. Partial Treatment Program is included as "Inpatient Mental Health Services" in the Schedule of Member Cost Sharing. A Partial Treatment Program is:

- A Program that involves any generally accepted form of evaluation and treatment of a condition diagnosed as mental illness that does not require full-time admission in a Hospital or treatment facility; and
- Is supervised by a psychiatrist who both reviews the Program and evaluates its effectiveness at least once per week.

A Partial Treatment Program includes:

- Day Care Treatment Program: A Partial Treatment Program provided to an individual during the day without a room charge, whether the Hospital or facility's treatment program is available for at least six (6) hours per day at least five (5) days per week.
- Night Care Treatment Program: A Partial Admission Program provided to an individual involving admission during the night with a room charge, whether the Hospital or facility's treatment program is available at least eight (8) hours per night and at least five (5) nights per week.

Residential Mental Health Treatment is treatment that takes place in a licensed mental health facility that has 24/7 supervision on a unit that is not locked. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as need. The treatment team is multidisciplinary and led by board certified psychiatrists. Residential Mental Health Treatment is included as Inpatient Mental Health Services in the Benefits-in-Brief. Residential treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that will allow the individual to successfully reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as a long term means of protecting others in the member's usual living environment; and
- Not based on a preset number of days such as standardized program (e.g., "30-Day Treatment Program").

Coverage:

The Plan Covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for mental health conditions. Coverage is provided for Medically Necessary Inpatient Mental Health Services, Outpatient Mental Health Services, Partial Treatment Program and Residential Mental Health Treatment as defined above. Mental Health Emergency Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 7.08.)

Limitations:

- Inpatient Mental Health Services, Partial Treatment Programs and Residential Mental Health Treatment each require Preauthorization by the Plan.
- Medical services required during a period of mental health admission must be Preauthorized separately by the Plan if Preauthorization is otherwise required.

Exclusions:

- Care provided in a non-licensed residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in:
  - Transitional living centers;
  - Domiciliary foster care facilities;
  - Therapeutic boarding schools;
  - Milieu therapies such as recreational or wilderness therapy programs that do not meet the requirements for Residential Mental Health Treatment as described above;
  - Custodial Care;
  - Halfway house services;
  - Three quarter house services.
- Counseling and other services for:
  - Insomnia and other non-medical sleep disorders;
  - Marital and relationship enhancement;
  - Religious oriented counseling provided by a religious counselor who is not an In-
  - Network Provider; and
  - Experimental/investigational or unproven treatments and services.

- See Part 8 for additional Exclusions.

7.19.02 SUBSTANCE ABUSE SERVICES/CHEMICAL DEPENDENCY

Definitions:

Detoxification means medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detoxification can occur in an Inpatient, Outpatient or residential setting.

Medically Monitored Intensive Inpatient Treatment is care provided in an inpatient facility or subacute unit following full or partial recovery from Acute Detoxification symptoms. These services are included as “Inpatient Substance Abuse Services” in the Schedule of Member Cost Sharing.

Partial Hospitalization is an intensive, non-residential level of service provided in a structured setting, similar in intensity to Inpatient treatment. A Member is generally in treatment for more than four (4) hours but generally less than eight (8) hours daily. These services are included as “Inpatient Substance Abuse Services” in the Schedule of Member Cost Sharing.

Residential Substance Abuse Treatment means Acute care services provided in a structured and secure full day (24 hour) setting to a Member who is ambulatory and does not require medical hospitalization. Residential Services may include 24-hour professional supervision and may also include counseling, Detoxification, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan. Residential Substance Abuse Treatment is sometimes also referred to as inpatient substance abuse treatment or rehabilitation ("rehab"). These services are included as "Inpatient Substance Abuse Services" in the Schedule of Member Cost Sharing.

Intensive Outpatient Programs are outpatient services provided by a variety of health professionals at a frequency of up to four (4) hours daily, and up to five (5) days per week. These services are included as "Outpatient Substance Abuse Services" in the Schedule of Member Cost Sharing.

Outpatient Treatment means Substance Abuse Services provided in an office setting, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day. These services are included as "Outpatient Substance Abuse Services" in the Schedule of Member Cost Sharing.

Coverage:

Medically Necessary Substance Abuse Services defined above are Covered under this plan. These include counseling, medical testing, diagnostic evaluation and Detoxification. Diagnosis and treatment may include drug therapy, counseling, Detoxification services, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Emergency Substance Abuse Services are Covered pursuant to Emergency and Urgent Care Coverage. (See Section 7.08)

Limitations:

- Medically Monitored Intensive Inpatient Treatment, Partial Hospitalization and Residential Substance Abuse Treatment require Preauthorization by the Plan.
- Medical Inpatient services required during a period of substance abuse admission must be Preauthorized separately by the Plan.

Exclusions:

- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, recreational or wilderness therapy programs, custodial care, halfway house services and health care aids.
- Care provided in a non-licensed residential or institutional facility, or other facility on a temporary or permanent basis is not Covered, including the costs of living and being cared for in:
  - Transitional living centers;
  - Domiciliary foster care facilities;
  - Therapeutic boarding schools;
  - Milieu therapies such as recreational or wilderness therapy programs that do not meet the requirements for Residential Substance Abuse Treatment as described above);
  - Custodial Care;
  - Halfway house services

    - Three Quarter house services.
- Also see Part 8 for additional Exclusions.

7.20 OUTPATIENT REHABILITATION

Outpatient rehabilitation includes:

- Medical rehabilitation, including cardiac and pulmonary rehabilitation
- Physical therapy
- Occupational therapy
- Speech therapy
- Breast cancer rehabilitation

Short-term Rehabilitation Services are Covered if:

- Treatment is provided for an illness, injury or congenital defect for which you have received corrective surgery;
- They are provided in an outpatient setting or in the home;
- They are not services provided by a federal or state agency or any local political subdivision, including school districts (i.e., such services are not payable by the Plan); and
- They result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment.

Exclusions:

- Cognitive retraining
- Vocational rehabilitation
- Therapy that provides no meaningful improvement in a Member's ability to do important day-to-day activities that are necessary in the Member's life roles within 60 days of starting treatment
- Services outside the scope of practice of the servicing provider
- Additional speech therapy exclusions
    - Chronic conditions or congenital speech abnormalities
    - Learning disabilities
    - Deviant swallow or tongue thrust
    - Voice therapy
    - Vocal cord abuse resulting from life-style activities

7.21 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

DME is equipment that must be used primarily for medical purposes. DME must be provided by a licensed provider. It must be intended for repeated use and be useful primarily as a result of illness, injury or congenital defect. Coverage is provided for rental or purchase, and is limited to basic equipment. If the cost of the DME is greater than the amount specified in the Schedule of Member Cost Sharing it must be Preauthorized by the Plan to be Covered. Please refer to the Schedule of Member Cost Sharing.

Note: All Medically Necessary equipment and supplies for the treatment of diabetes are Covered

(Preauthorization required for insulin pumps). See Section 7.05.

Limitations:

- The equipment must be considered DME by the Plan and be appropriate for home use;
- Your Provider must prescribe the equipment
- If the cost of the DME is greater than an amount specified in the Schedule of Member Cost Sharing it must be Preauthorized by the Plan to be Covered;
- The equipment is the property of the Plan or the supplier. When it is no longer Medically Necessary, you may be required to return it to the supplier; and
- Replacement of DME is Covered only when necessary to accommodate body growth, body change or normal wear.

Exclusions:

The equipment listed below is **not** Covered (there may be additional equipment that is not Covered):

- Deluxe equipment (such as motor-driven wheelchairs and beds) unless Medically Necessary for the patient and required so the patient can operate the equipment himself;
- Wheelchair seat elevators;
- Wheelchair power/manual standing feature;
- Items that are not considered medical items;
- Duplicate equipment;
- Items for comfort and convenience (such as bed boards, bathtub lifts, over-bed tables, adjustable beds, telephone arms, air conditioners, hot tubs, water beds);
- Physician's equipment (such as blood pressure cuffs and stethoscopes);
- Disposable supplies (such as sheets, bags, elastic stockings);
- Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills);
- Self-help devices that are not primarily medical items (such as sauna baths, elevators and ramps, special telephone or communication devices);
- Equipment that is experimental or for research;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement due to loss, theft or damage;
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and other equipment not intended for use in the home.

7.22 PROSTHETICS, ORTHOTICS AND CORRECTIVE APPLIANCES

DEFINITIONS

- Prosthetic devices help the body to function or replace a limb or body part after loss through an accident or surgery.
- Orthotic appliances are used to correct a defect of the body's form or function.
- Corrective appliances are items such as eyeglasses or contact lenses.
- Artificial aids are items such as cardiac pacemakers and artificial heart valves.

PROSTHETICS AND ORTHOTICS:

Coverage for prosthetics and orthotics INCLUDES

- Basic items and any special features that are Medically Necessary and, if the cost of an item exceeds the amount designated in the Schedule of Member Cost Sharing, is Preauthorized;
- The cost and fitting of a breast prosthetic device following a mastectomy;
- Replacement when necessary because of body growth, change or normal wear.

Limitations:

- The item must meet the Plan's definition of a prosthetic or orthotic item;
- If the cost of a prosthetic or orthotic exceeds an amount designated in the Schedule of Member Cost Sharing, the item must be Preauthorized by the Plan to be Covered.

Exclusions:

- Repair or replacement due to loss, theft or damage is not Covered.

CORRECTIVE APPLIANCES AND ARTIFICIAL AIDS

Coverage for corrective appliances and artificial aids is provided when the item is Medically Necessary and Preauthorized by the Plan.

Any implanted items such as cardiac pacemakers, dorsal spine stimulators and artificial heart valves are Covered as part of the Preauthorized inpatient/outpatient service. Prescription lenses (eyeglasses or contact lenses) are Covered immediately following surgery for eye diseases such as cataracts or to replace an organic lens that is missing from birth.

Exclusions:

The following are not Covered:

- Sports-related braces;
- All dental appliances;
- Hearing aids;
- Eyeglasses or contact lenses (except after surgery as listed above);
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics; and
- Devices or appliances that are experimental or for research.

7.23 REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES

7.23.01 INFERTILITY

Coverage is available for services for diagnosis, counseling and treatment of Infertility (including the underlying cause(s) of Infertility), except as specifically excluded below or under Part 8.
Artificial insemination for the treatment of Infertility includes:

- Intravaginal insemination (IVI)
- Intracervical insemination (ICI)
- Intrauterine insemination (IUI)

Following the initial sequence of diagnostic work-up and treatment, additional work-ups and treatment may begin only when the Plan determines they are in accordance with generally accepted medical practice and meet nationally recognized criteria. Coverage for pharmaceutical drugs prescribed as a part of this treatment are Covered pursuant to the terms and conditions of this Section.

Exclusions:

- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT- zygote intrafallopian transfer, and all related services and prescription drugs;
- Artificial insemination (except for treatment of Infertility); and
- All services related to surrogate parenting arrangements, including but not limited to, maternity and obstetrical care for non-Member surrogate parents.

7.23.02 GENETIC TESTING

The Plan Covers medically indicated genetic testing and counseling when they are Preauthorized by the Plan and provided in accordance with generally accepted medical practice. **Note:** Genetic testing for the BRCA gene for women will be Covered as a Preventive Service (Section 7.04) for women for whom the test is Medically Necessary and Preauthorized. Please contact Customer Services at (888) 327-0671 if you have questions.

7.23.03 VASECTOMY

The Plan Covers vasectomies when performed in a Physician's office or when performed in connection with another Covered inpatient or outpatient surgery.

Exclusion: Reversal of surgical sterilization.

7.23.04 TERMINATION OF PREGNANCY

The Plan Covers elective first trimester (3 months) termination of pregnancy, one in each two- year period of Plan Coverage.

Exclusion: Procedures in jurisdictions where the procedure is prohibited by law.

7.23.05 REPRODUCTIVE CARE AND FAMILY PLANNING

The Plan Covers the following services when they are provided in accordance with generally accepted medical practice:

- History
- Physical exam

- Lab tests
- Advice and medical supervision related to family planning.

7.24 ORAL SURGERY

Note: Also see Sections 7.25, 7.26 and 8.13.

Oral surgery and related services are Covered when Medically Necessary and Preauthorized by the Plan for:

- Prompt repair and treatment of fractures, suspected fractures of the jaw and facial bones and dislocation of the jaw immediately following an accident or traumatic injury;
- Prompt repair of injury to the jaw, tongue, cheeks, lips and roof or floor of the mouth immediately following an accident or traumatic injury;
- Prompt medical and surgical services required to correct accidental injuries, including emergency care to stabilize dental structures following injury to sound natural teeth immediately following an accidental or traumatic injury;
- Medically Necessary surgery for removing tumors and cysts within the mouth;
- Hospitalization for: (a) multiple extractions that must be performed in a Hospital due to a concurrent hazardous medical condition, or (b) when general anesthesia is required due to (i) Member's physical or mental condition, (ii) significant trauma in the facial area, (iii) the nature of a special procedure requires general anesthesia, or (iv) the Member's age along with other contributing factors necessitate the use of general anesthesia in a Hospital setting.

Note: "Immediately following" means treatment within 72 hours of the injury.

Exclusions:
- Routine dental care;
- Implants and repair/restoration of the teeth;
- Services provided by an individual who is not a licensed, practicing oral surgeon or a licensed medial or osteopathic physician.

7.25 TEMPOROMANDIBULAR JOINT SYNDROME (TMJ) TREATMENT

TMJ is a condition of muscle tension and spasms related to the temporomandibular joint, facial and/or cervical muscles that may cause pain, loss of function and/or physiological impairment. Medical services and treatment for TMJ listed below are Covered when they are Medically Necessary and Preauthorized by the Plan.

IMPORTANT: Dental services are not Covered.

Covered Services include:
- Office visits for medical evaluation and treatment;
- Specialty referral for medical evaluation and treatment;
- X-rays of the temporomandibular joint, including contrast studies; and
- Surgery to the temporomandibular joint including, but not limited to, condylectomy,

meniscectomy, arthrotomy and arthrocentesis.

Exclusions:

- Dental and orthodontic services or treatment, Prosthetics and appliances for or related to TMJ treatment; and
- Dental X-rays.

7.26 ORTHOGNATHIC SURGERY

Orthognathic surgery is oral surgery involving repositioning of an individual tooth, arch segment or entire arch, usually done in conjunction with a course of orthodontic treatment. The services listed below are Covered when they are Medically Necessary and Preauthorized by the Plan:

- Office consultation;
- Cephalometric study and X-rays;
- Orthognathic surgery;
- Postoperative care; and
- Hospitalization – only when it is Medically Necessary to perform the surgery in a Hospital setting.

Note: Orthodontic treatment is not Covered for any purpose, including orthognathic conditions.

7.27 PAIN MANAGEMENT

Evaluation and treatment of chronic and/or acute pain are Covered when Medically Necessary.

7.28 END STAGE RENAL DISEASE (ESRD)

Physician and facility services are Covered for the treatment of ESRD. Services may be provided in a Hospital, a freestanding facility or in the home.

Physician and facility services for the treatment of ESRD are Covered in coordination with Medicare. It is important that the Member with ESRD apply for Medicare coverage through the Social Security Administration. McLaren Health Advantage is the primary payer to Medicare for up to 33 months (this includes the three-month waiting period from the time the Member is diagnosed with ESRD), if the Member is under the age of sixty-five (65) and eligible for Medicare because of ESRD.
APPROVED CLINICAL **TRIALS**

Covered Services:

The Plan Covers Routine Patient Costs for items and services furnished in connection with a Qualified Individual's participation in An Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition.

For purposes of this Section, the following definitions apply:

- An Approved Clinical Trial means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.
- A Qualified Individual is a Member who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either (i) the referring health care professional has concluded that the Member's participation in such trial would be appropriate, or (ii) the Member provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.
- Routine Patient Costs include all items and services that would be Covered for a Member outside of participation in an Approved Clinical Trial.

Limitations:

- The Plan does not Cover the costs of the Approved Clinical Trial itself, but rather just the Routine Patient Costs (e.g., laboratory services) associated with the Approved Clinical Trial.
- Routine Patient Costs that otherwise require Preauthorization, also require Preauthorization when provided as part of an Approved Clinical Trial.

Exclusions:

The following are not Covered as Routine Patient Costs:

- The investigational item, device or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

7.30 CANCER DRUG THERAPY (ANTINEOPLASTIC SURGICAL DRUG THERAPY)

Covered Services:

Drugs for cancer therapy and the reasonable cost of administering them are Covered. These drugs are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used.

Coordination of Benefits for Drugs for Cancer Therapy and Cancer Clinical Trials

Coverage Benefits for drugs for cancer therapy will be payable under your prescription drug Coverage (Section 7.31) before being payable under other sections of this Benefits Document.

Limitations:

Routine patient costs incurred in connection with certain clinical trials may be Covered if approved in advance by the Plan Medical Director. See Section 7.29.

Exclusions:

Experimental, investigational or unproven services are not Covered. Additionally, certain drugs for which a majority of experts believe further studies or clinical trials are needed to determine toxicity, safety, or efficacy of the drug are not Covered.

7.31 PRESCRIPTION DRUG COVERAGE

Definitions:

Brand Name Drug: A prescription drug that the manufacturer markets under a registered trademark or trade name.

Compounded Drug: A medication that is the result of a combination, mix or alteration of one or more ingredients of a Drug or Drugs.

Covered Drug: A Tier 1, Tier 2, Tier 3 or Preventive Drug that is prescribed by a provider, included on the Plan Formulary and obtained through a pharmacy, except as excluded in this Benefits Document.

Dispense as Written or DAW: A Drug dispensed as written, with no substitutions (for example, "no substitution of a Tier 1 Drug").

Drug: A therapeutic agent; any substance, other than food, used in the prevention, diagnosis, alleviation, treatment or cure of disease.

Formulary: A listing of US Food and Drug Administration (FDA) approved prescription Drugs that the Plan has approved for use and are Covered under your Prescription Drug Coverage.

Generic Drug: A Drug whose patent has expired, that the FDA has determined to be bioequivalent to Brand Name Drugs and that is not manufactured or marketed under a registered trademark or brand name.

Mail-Order Pharmacy: A Prescription Brand Name Drug or a Generic Drug that can be dispensed through a mail-order service for a 90-day supply, and that is Covered with one (1) Copayment.

Off-Label: The use of a Drug or device for clinical indications, route of administration or dosage that exceeds the limitations stated in the manufacturer guidelines approved by the FDA.

Over-the-Counter Medications (OTC): Drugs that can be obtained without a prescription. A limited number of Over-the-Counter Medications are Covered. Refer to the Formulary at www.McLarenHealthPlan.org or contact Customer Service at (888) 327-0671 for the most current list of Covered Over-the-Counter Medications.

Preauthorization/Step Therapy Drugs: Drugs listed on the Plan's Formulary that require Plan review of a Member's medical information to ensure clinical criteria have been met regarding the Medical Necessity of the Drug. This review is performed by the Plan prior to approving Coverage and may involve the need for documentation of use of previous treatment with another Drug or result in the substitution of an alternative Drug. The Member is responsible for the cost of Step Therapy Drugs unless and until the Plan Preauthorizes the Drug.

Preferred Pharmacy: Licensed pharmacies selected by the Plan to provide Prescription Drugs to Members at lower Out-of-Pocket Member costs.

Prescription Drug: A medication approved by the FDA and which, under federal and state law, can be dispensed only pursuant to a prescription order.

Preventive Drug: Preventive Drugs are Prescription Drugs that have been recommended by the United States Preventive Service Task Force to help prevent illness. Some Preventive Drugs are Preventive Drugs only for specified age groups or genders. For more information see Section 7.04, Preventive Services.

Retail Pharmacy: A Preferred or non-Preferred Pharmacy having a state license to dispense medications to the general public at retail prices as a pharmacy. For purposes of this Benefits Document, Retail Pharmacy includes Pharmacies located in the McLaren Hospitals.

Specialty Drugs: A Drug included on the Plan Formulary that requires a difficult or unusual process of delivery to the patient (preparation, handling, storage, inventory, distribution, Risk Evaluation and Mitigation Strategy (REMS) programs, data collection or administration, or patient management prior to or following administration (monitoring, disease or therapeutic support systems)). These include, but are not limited to, medications to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, osteoporosis, and multiple sclerosis and oncology Drugs.

Tier 1 Drugs: A Plan Formulary Drug available with the lowest Copayment. This Tier includes many commonly prescribed low-cost drugs, including commonly prescribed Generic Drugs and may include other low-cost Drugs.

Tier 2 Drugs: This Tier includes preferred Brand Name Drugs. Drugs in this Tier will generally have lower Copayments than Non-Preferred Drugs.

Tier 3 Drugs: This Tier includes non-preferred Generic and non-preferred Brand Name Drugs. It also includes Specialty Drugs.

Coverage:
Coverage is provided for:

1. Tier 1, Tier 2, Tier 3 and Preventive Drugs when prescribed by a licensed Provider, obtained through a Pharmacy and, where required, Preauthorized by the Plan;
2. Injectable insulin when prescribed by a licensed Provider;
3. Disposable insulin needles and/or syringes;

4. Specialty Drugs when prescribed by a Provider and Preauthorized by the Plan;
5. Tier 2 or Tier 3 Brand Name Drugs and Preventive Brand Name Drugs by Mail-Order;
6. Compounded Drugs that are Preauthorized by the Plan; and
7. A limited number of Over-the-Counter Medications.

Copayments:

Refer to your Schedule of Member Cost Sharing and your Formulary for applicable Copayments. The Copayments will differ based on the following categories and rules:

- Preferred Retail Pharmacy or non-Preferred Retail Pharmacy
  - Tier 1 Drugs
  - Tier 2 Drugs
  - Tier 3 Drugs
  - Preventive Drugs

NOTE:

- **Contraceptive medications, devices or appliances:** Check your Formulary to confirm which are Covered with no Copayment (Preventive) and which are Covered with a Copayment.
- **Compounded Drugs:** Covered with the same Copayment as Tier 3 Drugs.
- **Covered Over-the-Counter Drugs:** Copayments vary by OTC Drug. Refer to your Formulary and the Schedule of Member Cost Sharing.

- **Mail-Order Pharmacy**
  - Tier 1
  - Tier 2
  - Tier 3 – Non-Preferred Generic, Non-Preferred Brand Only
  - Preventive Drugs

- **Specialty Drugs**
  - Must be filled at a Plan-designated specialty pharmacy
  - Specialty Drugs are limited to a 30 day supply.

Limitations:

1. Prescriptions Covered under this Plan are limited to a 30-day supply except as follows:
   - A ninety (90) day supply of Tier 1 or Preventive Drugs may be dispensed from a Retail Pharmacy if a Member successfully completes a thirty (30) day trial of the Drug. For Tier 1 Drugs, the 90-day supply may be obtained with one (1) Copayment.
   - A ninety (90) day supply of Tier 2 or Tier 3 Brand Name Drugs may be dispensed from a Retail Pharmacy if a Member successfully completes a thirty (30) day trial of the Drug. The 90-day supply may be obtained with three (3) Copayments.
   - If a Drug is available through the Mail-Order Pharmacy, a 90-day supply may be dispensed by the Mail Order Pharmacy with one (1) Copayment if a Member successfully completes a thirty (30) day trial of the Drug.

- We reserve the right to place a maximum supply limit on certain Covered Prescription Drugs. The Plan does not Cover any prescription refill in excess of the number specified by the physician or any prescription or refill dispensed after one year from the date of the physician's order.

2. If a Tier 2 Drug is dispensed when a Tier 1 Drug equivalent is on the Plan Formulary, the Member must pay the difference between the cost of the Tier 2 Drug and the price of its Tier 1 equivalent in addition to the applicable Copayment. A Tier 2 or Tier 3 Drug will be Covered at the same level as a Tier 1 Covered Drug if we grant Preauthorization of the Drug on the basis that the Drug is a Medically Necessary and appropriate alternative, or if a Tier 1 equivalent is not available. If Preauthorization is requested, the Member or his/her provider must provide us with all information necessary to determine whether the Preauthorization should be granted. We shall provide a decision regarding the request within twenty-four (24) hours after receiving all such information. For urgent situations, see also Section 1.05, Expedited Formulary Exception Requests.
3. A Compounded Drug must meet the following additional requirements in order to be Preauthorized and Covered:
   - FDA-approved for the route of administration and medical condition for which it is prescribed;
   - At least one of the ingredients of the Compound is an FDA-approved Prescription Drug; and
   - Must be billed to the Plan electronically by a Preferred Retail Pharmacy. Paper claims from non-Preferred pharmacies will not be approved.
4. Any Drug or device prescribed for use or dosage other than those specifically approved by the FDA and the reasonable cost of Medically Necessary supplies to administer them are Covered if the prescribing provider can substantiate that the Drug is recognized for treatment of a condition for which it was prescribed and the Drug or device is Preauthorized by the Plan. If Preauthorization is requested, the Member and his/her provider must provide the Plan with all supporting documentation necessary to determine whether the Preauthorization should be granted. Documentation of the following is required:
   - The Drug is approved by the FDA;
   - The Drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:
     - A life-threatening condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on the Plan's Formulary or accessible through the Plan's Formulary procedures;
     - A chronic and seriously debilitating condition so long as the Drug is Medically Necessary to treat that condition and the Drug is on the Plan's Formulary or accessible through the Plan's Formulary procedures.
   - The Drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:
     - The American Medical Association Drug evaluations;
     - The American hospital formulary service Drug information;
     - The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".
   - Two articles from major peer-reviewed medical journals that present data supporting the proposed Off Label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

For purposes of this Section:

- "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration, and that causes significant long-term morbidity.
- "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.
- The Plan shall provide a decision regarding the request within twenty- four (24) hours after receiving all of such information. For urgent situations, see also 1.05, Expedited Formulary Exception Requests.

5. An Over-the-Counter Medication requires a prescription from a Tier 1 Provider and must be included on the Plan Formulary.
6. In order for the Plan to better manage available manufacturer-funded copay assistance, copays for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to the Member be greater than the maximum copayment published in the Schedule of Cost Sharing.

Finally, manufacturer-funded copay assistance received will not be credited to your annual deductible or Out of Pocket Maximum.

Exclusions:

1. There is no Coverage for Drugs, needles and syringes, or insulin provided by any private or public agency that are or may be obtained by the Member without cost to the Member.
2. There is no Coverage for any Drug that is experimental or that is being used for experimental purposes including, but not limited to, those regarded by the FDA as investigational.
3. There is no Coverage for any prescription that is filled after the Termination of Coverage or that is filled prior to termination of Coverage but provides more than a 30-day supply beyond the Termination date.
4. There is no Coverage for any cosmetic Drug or Drug used for cosmetic purposes. "Cosmetic Drug" or "cosmetic purpose" means any prescription legend Drug that is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting or reducing hair growth, reducing or eliminating wrinkles or altering the appearance, and any substance intended to be used as a component of the above Drugs.
5. Some Preventive Drugs, such as certain vaccines, are Covered under Section 7.04 of the Benefits Document, and are subject to the benefits and limitations of that Section.
6. Certain other Drugs are Covered elsewhere in this Benefits Document as a part of medical Benefits (e.g., serums, Drugs for treatment of Infertility, certain cancer Drugs). They are not Covered under this Section, but are subject to Benefits, limitations, exclusions, Copayment, Coinsurance, Deductible and Preauthorization requirements of the other applicable sections of this Benefits Document.
7. There is no Coverage for any Prescription Drug, insulin, or needles and syringes to the extent that benefits or coverage are available under Medicare or under any health care program

supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

8. There is no Coverage for any Drug, needles or insulin that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or prescribed for the Member in accordance with generally accepted professional procedures.
9. There is no Coverage for Prescription Drugs for which there is an Over-the- Counter equivalent in both strength and dosage form.
10. There is no Coverage for medications that are not regulated by the FDA such as medical foods or herbal supplements.
11. There is no Coverage for the replacement of Drugs that are lost, stolen or damaged.
12. Discounts, coupons, or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your specialty medications or other Drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not be counted toward the Out of Pocket Maximum or Deductible. Only the amount that you pay separate and apart from the financial assistance will be credited as true out-of- pocket payment that will apply to your annual maximum out-of-pocket requirement. For example, if your cost is reduced by a Copayment assistance card, manufacturer coupon or other drug assistance program (other than those the Plan is required to accept by law), only the amount you actually pay will accumulate toward your Deductible, if applicable, or Out of Pocket Maximum.
13. There is no Coverage for Drugs not included on the Plan Formulary. **NOTE** please check the formulary at www.MclarenHealthPlan.org for Coverage of drugs as the Formulary changes periodically to add or remove drugs.

7.32 SERVICES FOR GENDER TRANSITION

The Plan Covers Medically Necessary services related to gender dysphoria or gender transition. Such services will be subject to the applicable Member cost sharing and limitations otherwise applicable. (*e.g.*, see Section 7.10 Inpatient hospitalization, Section 7.19 Mental Health Services, Part 8 Exclusions)

Limitations:

- Gender reassignment surgery must be Preauthorized

Exclusions:

- Reversal of prior gender reassignment surgery;
- Surgery that is considered cosmetic in nature and not Medically Necessary when performed as a component of a gender reassignment;
- Services, treatment and surgeries that are considered Experimental and Investigative;
- Exclusions under other benefits (e.g., see Inpatient hospitalization, Outpatient Habilitative Services, Outpatient Rehabilitative Services, Reproductive Care and Family Planning Services, Prescription Drugs, Mental Health Services, and Exclusions

7.33 ABA THERAPY

The Plan Covers Applied Behavioral Analysis or ABA is Covered when provided by a provider who has the appropriate credentials;

Limitations:

- ABA services must be Medically Necessary as determined by the Plan

Exclusions:

- All other habilitation services

PART 8: EXCLUSIONS AND LIMITATIONS

This section lists exclusions and limitations of your Plan Coverage. Also refer to a specific service within this Benefits Document for additional exclusions and limitations for that service.

8.1 UNAUTHORIZED SERVICES

Services requiring Preauthorization by the Plan will not be paid without such Preauthorization. Although Providers may assist in obtaining Plan Preauthorization, the Member is ultimately responsible for ensuring that any necessary Preauthorization has been obtained.

8.2 3SERVICES THAT ARE NOT MEDICALLY NECESSARY

Services that are not Medically Necessary are not Covered unless specified in the Benefits Document. The final determination of Medical Necessity is the judgment of the McLaren Health Advantage Chief Medical Officer.

83 NONCOVERED SERVICES

- Office visits, exams, treatments, test and reports for any of the following are not Covered:
  - Employment
  - Licenses
  - Insurance
  - Travel (only immunizations for purposes of travel are Covered Benefits)
  - School purposes
  - Legal Proceedings, such as parole, court and paternity requirements
- Housekeeping services;
- Court-related services and marital counseling;
- Outpatient rehabilitation services related to vocational rehabilitation;
- Recreational therapy;
- Speech therapy related to chronic conditions or congenital speech abnormalities, learning disabilities, deviant swallow or tongue thrust, and vocal cord abuse resulting from life-style choices;

- Deluxe DME such as motor-driven wheelchairs and beds, unless Preauthorized, Medically Necessary and required so that the patient can operate the equipment himself;
- Items that are not considered medical items;
- Duplicate DME;
- Physician's equipment such as blood pressure cuffs and stethoscopes;
- Disposable supplies such as sheets, bags and elastic stockings;
- Exercise and hygienic equipment such as exercycles, treadmills, bidet toilet seats and bathtub seats;
- Self-help devices that are not primarily medical items such as sauna baths, elevators and ramps, special telephone or communication devices;
- Needles and syringes for purposes other than the treatment of diabetes;
- Repair or replacement of DME, prosthetics, orthotics, and corrective appliances due to loss, theft or damage;
- Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and such equipment not intended for use in the home;
- Sports-related braces;
- Dental appliances;
- Hearing aids;
- Eyeglasses or contact lenses except after a Preauthorized surgery for eye diseases such as cataracts or to replace an organic lens that is missing from birth (see Section 7.22);
- Non-rigid appliances and supplies such as (but not limited to) elastic stockings, garter belts, arch supports, corsets, corrective shoes, wigs or hair pieces, shoe or foot orthotics;
- Meals and lodging for organ transplant donors; and
- All other services specifically defined as "not Covered" or a Benefit exclusion in this Benefits Document.

8.4 COSMETIC SURGERY

Cosmetic surgery is surgery primarily to reshape normal structures of the body, improve appearance and self-esteem. We do not Cover cosmetic surgery or any of the related services, such as pre- or post-surgical care, follow-up care, reversal or revision of the surgery or treatment for complications.

8.5 MILITARY CARE

We do not Cover any care for diseases or disabilities connected with military service if you are legally entitled to obtain services from a military facility, and such a facility is available within a reasonable distance.

8.6 CUSTODIAL CARE

The Plan does not Cover any custodial care, i.e., care that is primarily for maintaining the Member's basic needs for food, shelter and clothing. This means that custodial care is not Covered in settings such as your home, a nursing home, residential institution or any other setting that is not required to support medical and skilled nursing care. Further, we do not Cover Custodial (non-skilled) care when received in a home or facility on a temporary or permanent basis. Examples of such care include three-quarter house or half-way house placement, room and board, health care aids and personal

care designed to help in activities of daily living or to keep from continuing unhealthy activities.

8.7 COMFORT ITEMS

The Plan does not Cover any personal or comfort items, such as telephone or television. The Plan does not Cover the costs of a private room or apartment.

8.8 RESEARCH OR EXPERIMENTAL SERVICES

The Plan uses the following criteria when evaluating new technologies, procedures and drugs:

- Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials;
- Evidence of patient safety when used in the general population;
- Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting;
- Evidence of clinically meaningful outcomes; and
- Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

Covered Services:

Coverage is available for Routine Patient Costs in connection with an Approved Clinical Trial (see Section 7.29). For information about which trials are Covered, a Member's physician should contact the Plan's Chief Medical Officer.

Non-Covered Services:

- Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:
- The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States;
- An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy;
- The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy;
- Reliable Evidence shows that the drug, device, treatment or procedure is:
  - Under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
  - Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.
- **Reliable Evidence** includes any of the following:
  - Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
  - A written protocol or protocols used by the treating facility or the protocol(s) of another

facility studying the same or a similar drug, device, treatment or procedure; or
- Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device or procedure.

8.9 NON-MEDICAL SERVICES

We do not Cover non-medical services including enrichment programs such as dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes. These services may be paid as part of a treatment program, but they are not payable separately as long as they are expected to improve the Member's condition.
Additionally, we do not Cover fees related to parenting arrangements of any kind, not including maternity care and services.

8.10 HABILITATION SERVICES

This Plan does not Cover Habilitation Services except for ABA services for treatment of Autism.

8.11 COURT-RELATED SERVICES

The Plan does not Cover pretrial and court testimony, court-ordered exams that do not meet Plan requirements for Coverage, and the preparation of Court-related reports;
The Plan does not Cover court-ordered examinations, tests, reports, or treatments that do not meet requirements for Coverage under this Benefits Document, including but not limited to Mental Health or Substance Abuse Services Coverage.

8.12 ELECTIVE PROCEDURES

The following elective procedures are not Covered:
- Reversal of surgical sterilization;
- In-vitro fertilization procedures, such as GIFT-gamete intrafallopian transfer or ZIFT- zygote intrafallopian transfer and all related services;
- Artificial insemination (except for treatment of Infertility);
- All services related to surrogate parenting arrangements, including, but not limited to, maternity and obstetrical care for non-Member surrogate parents;
- Services provided by a lay-midwife and home births; and
- Procedures that are not Preauthorized by the Plan as required in this Benefits Document.

8.13 DENTAL SERVICES

We do not Cover dental services, dental Prosthetics, dental appliances, replacement of teeth, X- rays, orthodontic treatment, oral surgery or anesthesia for procedures relating to the teeth except as stated in Sections 7.24, 7.25 and 7.26.

8.14 SERVICES COVERED THROUGH OTHER PROGRAMS AND THE PUBLIC SECTOR

The Plan does not Cover any services that are available to you under the following circumstances:

- Under an extended benefits provision of any other health insurance or health benefits plan, policy, program or certificate;
- Under any other policy, program, contract or insurance as stated in **Part 3: Other Party Liability;**
- Under any public health care, school or public program supported totally or partly by state, federal or local governmental funds, except where this Plan's Coverage is required by law to be your primary coverage;
- Under any contractual, employment or private arrangement (not including insurance) that you made that promises to provide, reimburse or pay for health, medical or hospital services; and
- Services available through the public sector. Such services include, but are not limited to, psychological and neurological testing for educational purposes, services related to adjustment to adoption, group home placement or Assertive Community Treatment.

8.15 ALTERNATIVE SERVICES

Any alternative service (treatments not traditionally being used in standard Western medicine and not widely taught in medical schools), including, but not limited to, acupuncture, herbal treatments, massage therapy, light therapy, therapeutic touch or aromatherapy is not Covered. Evaluations and office visits related to alternative services are also not Covered.

8.16 VISION SERVICES

Except as specifically otherwise stated in this Benefits Document, the following vision services or items are not Covered:

- Radial keratotomy;
- Routine non-medically necessary vision and optometric exams;
- Refractions, unless Medically Necessary;
- Glasses, frame and contact lenses;
- Dilation;
- Visual training; and
- Dyslexia treatment.

8.17 ILLEGAL OCCUPATION

The Plan shall not be liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member being engaged in an illegal occupation. This includes services resulting from operating while intoxicated (OWI), operating while visibly impaired (OWVI) and operating an illegal laboratory for the manufacture of methamphetamine.

8.18 CARE RENDERED WHILE IN POLICE CUSTODY

Services provided to a Member while in police custody are not Covered. Police custody includes, but is not limited to any time a Member is not free to go, including when a Member was not issued bond.

8.19 SERVICES PROVIDED BY FAMILY OR HOUSEHOLD MEMBER(S)

Coverage is not available for services provided to the Member by the Member, immediate family members of the Member or individuals that have the same legal residence as the Member.

8.20 HEALTH EDUCATION OR HEALTH COUNSELING

Except as specifically stated as Covered in this Benefits Document or included as a Preventive Service, health education and health counseling services may be arranged through your Provider but are not Covered; they are payable by the Member.

8.21 NO SHOW CHARGES

Any missed appointment fee charged by a provider because you failed to show up at an appointment is not Covered.

8.22 ADDITIONAL EXCLUSIONS

Some services described in this booklet may be excluded in the Schedule of Member Cost Sharing. When there is a conflict between this booklet and the Schedule of Member Cost Sharing, the Schedule of Member Cost Sharing will supersede.

8.23 ILLEGAL SERVICES

Services that are prohibited to be performed by applicable law are not Covered.

MCLAREN HEALTH ADVANTAGE PREMIER PLUS – 2027

SCHEDULE OF MEMBER COST SHARING

This document is a part of your McLaren Health Advantage Medical Benefits Document. It provides you with detailed information about member out-of-pocket expenses and certain limitations of coverage. It does not include all conditions of coverage; refer to your Health Benefits booklet for additional terms of coverage, especially preauthorization requirements.

	Tier 1 Providers	**Tier 2 Providers**	**Out-of-Network All other Hospitals and Physicians**
Annual Deductible	$200 Individual $400 Family	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family
Medical Coinsurance Out-of-Pocket Maximum	$500 Individual $1,000 Family	$3,000 Individual $6,000 family	$3,000 Individual $6,000 family
Total Out-of- Pocket Maximum*	$9,200 Individual $18,400 Family		$13,000 Individual $26,000 Family

*Your total OOPM can be met by satisfying your deductible(s) coinsurance maximum amounts and applicable medical and pharmacy copays through a calendar year.

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Preventive Services	$0	100% No Coverage	100% No Coverage	
Diabetic Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Primary Care Physician (PCP) Office Visits	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Specialist Office Visit	$30 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Allergy Testing and Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Immunizations (other than Preventive Care)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Maternity Care (Prenatal and Postnatal Visits, Delivery and Routine Nursery Care)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Injectable Drugs Provided in the Physician Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Spinal Treatment	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 24 visits per Plan Year

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Emergency Care – Emergency Room	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	
Urgent Care	$25 Copayment No Deductible	$25 Copayment No Deductible	$25 Copayment Plus Balance Bill No Deductible	
Ambulance	100%	100%	Provider Balance Bill*	*Surprise billing rules prohibiting balance billing may apply for certain air ambulance services
Inpatient and Long-Term Acute Hospital Services (including Consultations by a Physician)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	When McLaren Hospital (facility) is used, Deductible is waived for the facility service. However, you may be billed for professional (provider) services to which applicable Deductible and Coinsurance will apply.
Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Diagnostic and Therapeutic Services and Tests (e.g., therapeutic radiology, diagnostic radiology, diagnostic laboratory and pathology services)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	For laboratory services, only Domestic and Preferred Laboratory Providers[11] are considered In-Network. All other laboratories are Out-of-Network with Provider Balance Bill.

[1] JVHL is the Preferred Laboratory Provider.

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Organ and Tissue Transplants	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Special Surgical Procedures	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Breast Reconstruction Following Mastectomy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Skilled Nursing Facility Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 120 days per Plan Year
Home Care Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Hospice Care	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Outpatient Mental Health Services	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Mental Health Services (Including Partial Treatment Programs and Residential Mental Health Treatment)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Emergency Mental Health Services	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Outpatient Substance Abuse Services	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Substance Abuse Services (Including Partial Hospitalization and Residential Substance Abuse Treatment)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Emergency Substance Abuse Services	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	
Outpatient Habilitation Services	100% Not Covered	100% Not Covered	100% Not Covered	
Outpatient Rehabilitation (Physical, Speech and Occupational Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 60 visits, per condition, per Plan Year
Durable Medical Equipment (DME) and Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if: • Purchase price is $5,000 or more • Rental is $500 or more per month
Prosthetics, Orthotics and Corrective Appliances	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if purchase price is $5,000 or more
Reproductive Care and Family Planning Services (including Diagnosis of Infertility, Genetic Testing, Vasectomy and Termination of Pregnancy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Oral Surgery, TMJ Treatment and	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider	

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Orthognathic Surgery			Balance Bill	
Pain Management	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
End Stage Renal Disease (Physician and Facility Services)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	
Cancer Drug Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
NICU	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Burn	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
High Risk OB	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Applied Behavior Analysis (ABA) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Tier 1 (Preferred Generic)	NA*	$10 Copayment[2] No Deductible	$10 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 2 (Preferred Brand)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - $10 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $30 Copayment[2] No Deductible	$30 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 3 (Non-Preferred Generic, Non-Preferred Brand Drugs)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Non-Preferred Generics - NA* Non-Preferred Brand - $15 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $50 Copayment[2] No Deductible	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Tier 3 (Non-Preferred Generic, Non-Preferred Brand Drugs)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Non-Preferred Generics - NA* Non-Preferred Brand - $15 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $50 Copayment[2] No Deductible	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 3 Specialty Drugs	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[4, 5] All other - $5 Copayment No Deductible[4]	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[4, 5] All other - $50 Copayment No Deductible [4]	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Preventive Drugs	NA*	$0[2] No Deductible	25% of Reimbursement Amount Paid by Plan No Deductible

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Mail Order Drugs	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Preferred Generic - NA* Non-Preferred Generic - NA* Preferred Brand - $10 Copayment for 3-month supply[6] No Deductible Non-Preferred Brand - $15 Copayment for 3-month supply[6] No Deductible Preventive – NA*	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5] All other - Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand Name Drugs and Preventive Drugs) - One Copayment (as applicable) for a 3-month supply[3] No Deductible	One Copayment (as applicable) for a 3-month supply[3] Plus 25% of Reimbursement Amount Paid by Plan No Deductible

NOTE: For a complete description of benefits, further limitations, conditions, and exclusions, also refer to the Health Benefits booklet. Benefits are subject to change or revision without notice, and this form is not a guarantee of past or future benefits. For McLaren Health Advantage, "covered" out-of-network services means that the services are payable at McLaren Health Advantage's reimbursement amount, less any applicable deductible, coinsurance and/or copayment required by the plan. If you choose to see an out-of-network provider, you may be responsible for any "Balance Billed" monetary difference between McLaren Health Advantage's reimbursement amount and the non-contracted, out-of-network provider's billed charges. Balance Billing can occur when receiving care from a non-contracted, out-of-network provider.

*NA = Not Available

[2] A 3-month supply of Tier 1, Tier 2, Tier 3 non-preferred generic and non-preferred brand and preventive drugs may be obtained from a retail pharmacy if a

member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment for Tier 1 drugs, and three copayments for Tier 2 and Tier 3 non-preferred generic and non-preferred brand drugs.

[3] A 3-month supply of Tier 1, Tier 2, Tier 3 non-preferred generic and non-preferred brand drugs and preventive brand drugs may be obtained through mail order if a member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment for Preferred Pharmacies. A 3-month supply may be obtained with one copayment plus 25% of Reimbursement Amount paid by plan for Non-Preferred Pharmacies.

[4] Limited to up to a 30-day supply.

[5] However, in no case will true out-of-pocket costs to the Member be greater than the Copayment specified for the drug above (e.g., $50

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MHA20170620 Rev. 2024

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