The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at mclarenhealthplan.org or call Customer Service at (888) 327-0671. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call (888) 327-0671 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1 Providers: $200/person/$400/family, For Tier 2 Providers $1,000/person/$2,000/family, Out-of-Network Providers: $1,000/person / $2,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, the deductible doesn't apply to preventive care for Tier 1 Providers, and certain services subject to flat dollar copayments.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 and Tier 2 Providers: $9,200/person/$18,400/family For Out-of-Network Providers: $13,000/person/$26,000/family Discounts, coupons, or similar financial assistance provided by drug manufacturers are not included.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover. Discounts, coupons or similar financial assistance provided by drug manufacturers are not included.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.McLarenHealthAdvantage.org or call (888) 327-0671 for a list of network providers.	This plan uses a provider network. This plan uses separate tiered networks for medical and pharmacy. For medical, you will pay less if you use a provider in the

Important Questions	Answers	Why This Matters:
		plan's network (a "Participating Provider". For medical, you will pay more if you use Tier 2 Provider. For pharmacy, you will pay less if you use a KSP provider. You will pay more if you use a Preferred Pharmacy. You will pay the most if you use a non-Participating Provider, and you might receive a bill from a provider for the difference between the Provider's charge and what your plan pays (balance billing). Be aware your Participating Provider might use a non-Participating Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copayment /visit Deductible does not apply	40% Coinsurance;	40% Coinsurance plus Balance Bill	None.
	Specialist visit	$30 Copayment/visit Deductible does not apply	40% Coinsurance;	40% Coinsurance plus Balance Bill	Plan Preauthorization for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment.
	Preventive care/screening/ immunization	No charge Deductible does not apply	Not covered	Not covered	Plan Preauthorization for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization is required for genetic testing. The penalty for not having prior authorization is denial of payment.

[* For more information about limitations and exceptions, see the plan or policy document at mclarenhealthadvantage.org.]

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization is required. The penalty for not having prior authorization is denial of payment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.mclarenhealthplan.org/mhcc-member/formulary-lookup-mhp	Generic drugs – Tier 1 (Preferred Generic drugs)	**KSP Pharmacy** Not Covered	**Preferred Pharmacy** $10 Copayment/ Prescription Deductible does not apply	$10 Copayment/ Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. Deductible does not apply	Plan Preauthorization is required for some drugs. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx A 90-day supply of Brand Name Drugs or Generic Drugs may be dispensed from a Mail Order or Retail Pharmacy if a Member successfully completes a 30-day trial of the Drug. If a Copayment applies, the 90-day supply may be obtained with one Copayment. For Non-Preferred Pharmacies, one Copayment (as applicable) plus 25% of Reasonable and Customary Amount Paid by Plan. For KSP Pharmacy – If a Member successfully completes a 30-day trial of the Drug, a 90-day supply of Preferred Brand may be obtained for a $10 Copayment and a 90-day supply of Non-Preferred Brand may be obtained for a $15 Copayment. The penalty for not having prior authorization is denial of payment. For drugs subject to the PBM variable copayment program, copayment program, in no case will true out-of-pocket costs to the
	Preferred brand drugs – Tier 2 (Preferred brand drugs)	**KSP Pharmacy** If obtained through the PBM variable copayment program – Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other - $10 Copayment / Prescription Deductible does not apply	**Preferred Pharmacy** If obtained through the PBM variable – Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other - $30 Copayment/ Prescription Deductible does not apply	$30 Copayment/ Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. Deductible does not apply	
	Non-preferred brand drugs – Tier 3 (Non-preferred generic and non-preferred brand	**KSP Pharmacy** If obtained through the PBM variable copayment program – Variable Copayment	**Preferred Pharmacy** If obtained through the PBM variable copayment program – Variable Copayment	$50 Copayment/ Prescription plus 25% of Reasonable and Customary Amount Paid by Plan.	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	drugs)	subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other- Non-preferred brand: $15 Copayment/ Prescription Deductible does not apply Non-preferred generics: Not Covered	subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other - $50 Copayment/ Prescription Deductible does not apply	Deductible does not apply	Member be greater than the Copayment specified for a fill (e.g., $50 Copayment for a non-preferred generic and non-preferred brand drug).
	Specialty drugs – Tier 3	**KSP Pharmacy** If obtained through the PBM variable copayment program – Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other - $5 Copayment / Prescription	**Preferred Pharmacy** If obtained through the PBM variable copayment program – Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program Deductible does not apply All other - $50 Copayment/ Prescription	$50 Copayment/ Prescription plus 25% of Reasonable and Customary Amount Paid by Plan. Deductible does not apply	Specialty drugs must be filled at a Plan-designated specialty pharmacy. Coverage is limited to a 30 day supply. Plan Preauthorization is required. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx The penalty for not having prior authorization is denial of payment. For drugs subject to the PBM variable copayment Program, in no case will true out-of-pocket costs to the Member be greater than the Copayment specified for a fill (e.g., $50 Copayment for a specialty drug).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
		Deductible does not apply	Deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization for some services is required. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment.
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	
If you need immediate medical attention	Emergency room care	$100 Copayment/visit Deductible does not apply	$100 Copayment / visit Deductible does not apply	$100 Copayment / visit Deductible does not apply	None.
	Emergency medical transportation	No Charge	No Charge	Provider Balance Bill	Emergency medical transportation from a Non-Participating Provider may result in a balance bill. *Surprise billing rules prohibiting balance billing may apply for certain air ambulance services
	Urgent care	$25 Copayment /visit Deductible does not apply	$25 Copayment /visit Deductible does not apply	$25 Copayment /visit Deductible does not apply	Urgent care from a Non-Participating Provider may result in a balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization is required for the service to be Covered (with the exception of Maternity Care.) The penalty for not having prior authorization is denial of payment.
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copayment/visit Deductible does not apply	40% Coinsurance	40% Coinsurance plus Balance Bill	None.
	Inpatient services	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization is required for the service to be Covered. The penalty for not having prior authorization is denial of payment.
If you are pregnant	Office visits	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	

[* For more information about limitations and exceptions, see the plan or policy document at mclarenhealthadvantage.org.]

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	services				
	Childbirth/delivery facility services	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Plan Preauthorization is required for the service to be Covered. Housekeeping services and custodial care are excluded. The penalty for not having prior authorization is denial of payment.
	Rehabilitation services	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Limited to 60 visits, per condition, per Plan year.
	Habilitation services	ABA Services – 10% Coinsurance All other – Not Covered	ABA Services – 40% Coinsurance All other – Not Covered	ABA Services – 40% Coinsurance plus Balance Bill All other – Not Covered	None
	Skilled nursing care	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	120 days annual maximum
	Durable medical equipment	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	Durable medical equipment with a purchase price of $5,000 or more or a rental cost of $500 or more per month requires Plan Preauthorization. See Section 7.03 of your MHA Benefit Booklet. The penalty for not having prior authorization is denial of payment.
	Hospice services	10% Coinsurance	40% Coinsurance	40% Coinsurance plus Balance Bill	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

[* For more information about limitations and exceptions, see the plan or policy document at mclarenhealthadvantage.org.]

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Pediatric)	• Habilitative Care • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery • Chiropractic care	• Infertility services • Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform . Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Health Insurance Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: McLaren Health Advantage, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also contact the Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

Language Access Services:

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

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

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

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

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

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[* For more information about limitations and exceptions, see the plan or policy document at mclarenhealthadvantage.org.]

About these Coverage Examples:

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

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$770**

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$700
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$990**

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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