
 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, 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 www.McLarenHealthPlan.org or call (888) 327-0671 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See McLarenHealthPlan.org or call (888) 327-0671 for a list of <u>network providers</u> .	You pay the least if you use a <u>Participating Provider</u> . You might receive a bill from a <u>Non-Participating I/T/U Provider</u> for the difference between the <u>Provider's</u> charge and what you <u>plan</u> pays (<u>balance billing</u>). You will pay the most if you use a <u>non-Participating Provider/non-I/T/U Provider</u> , and you might receive a bill from a <u>Provider</u> for the difference between the <u>Provider's</u> charge and what you <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>Participating Provider</u> might use a <u>non-Participating Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> . Note, however, that some services require <u>plan Preauthorization</u> in order to be covered.

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

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-Participating I/T/U Provider	Non-Participating & Non-I/T/U Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage. Plan <u>Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
	Specialist visit	No charge <u>Deductible</u> does not apply.	Provider balance bill		
	Preventive care/screening/immunization	No charge <u>Deductible</u> does not apply.	Provider balance bill		
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> is required for genetic testing. Plan <u>Preauthorization</u> is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx .	Tier 1 (Preferred Generic drugs)	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> is required for some drugs. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx
	Tier 2 (Preferred Brand drugs)				
	Tier 3 (Non-Preferred Generic and Non-Preferred Brand drugs)				
	Specialty drugs				Only Brand Drugs are Covered. Plan <u>Preauthorization</u> is required. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-Participating I/T/U Provider	Non-Participating & Non-I/T/U Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
	Physician/surgeon fees				
If you need immediate medical attention	Emergency room care	No Charge	Provider balance bill	Provider balance bill	Emergency room care from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	Emergency medical transportation	No Charge	Provider balance bill	Provider balance bill	Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	Urgent care	No Charge			Urgent care from a Non-Participating Provider may result in a <u>balance bill</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.)
	Physician/surgeon fees				
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Plan <u>Preauthorization</u> is required for Inpatient services other than maternity to be Covered.
	Inpatient services				
If you are pregnant	Office visits	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services				
	Childbirth/delivery facility services				
If you need help recovering or have	Home health care				Physical and Occupational Therapy
	Rehabilitation services				

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-Participating I/T/U Provider	Non-Participating & Non-I/T/U Provider	
<p>other special health needs</p> <p>If you need help recovering or have other special health needs</p> <p>If you need help recovering or have other special health needs</p>		No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum: 30 visits annual max for each. Chiropractic services are limited to 20 visits of the 30 visit maximum. <u>Plan Preauthorization</u> is required for the service to be Covered.
	Habilitation services	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum; 30 visits annual max for each. Chiropractic services are limited to 20 of the 30 visit maximum. <u>Plan Preauthorization</u> is required for the service to be Covered.
	Skilled nursing care				60 days annual max
	Durable medical equipment				Durable medical equipment that costs \$3,000 or more requires <u>Plan Preauthorization</u> .
	Hospice services				Inpatient hospice services require <u>Plan Preauthorization</u> . 45 days annual max for inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Benefit maximum: 1 eye exam per calendar year.
	Children's glasses				Benefit maximum: 1 pair of glasses per calendar year.
	Children's dental check-up	Not Covered	Not Covered		Not Covered

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

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Abortions• Acupuncture• Cosmetic surgery• Dental care (Pediatric)• Dental care (Adult) | <ul style="list-style-type: none">• Hearing aids• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult)• Routine foot care |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|
| <ul style="list-style-type: none">• Bariatric surgery• Chiropractic care | <ul style="list-style-type: none">• 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: your state insurance department at the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Insurance and Financial Services (DIFS) at (877) 999-6442. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877-999-664 or DIFS-HICAP@Michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:



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

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] \$0
- Other [*cost sharing*] \$0

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

Total Example Cost	\$12,671
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
Copayments	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] \$0
- Other [*cost sharing*] \$0

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

Total Example Cost	\$7,334
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
Copayments	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$55

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] \$0
- Other [*cost sharing*] \$0

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

Total Example Cost	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
Copayments	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0