
 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 <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 ? | \$250/individual or \$500/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 all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$1,000/individual or \$2,000/family | 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 ? | Copayments for certain services, premiums , balance-billing charges and health care this plan doesn't cover. | 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 McLarenHealthPlan.org or call (888) 327-0671 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network (a " Participating Provider "). 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 . Note, however, that some services require plan Preauthorization in order to be covered. |

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

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$10/visit <u>Deductible</u> does not apply. | Not Covered | None. |
| | Specialist visit | \$15/visit <u>Deductible</u> does not apply. | Not Covered | <u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage. |
| | Preventive care/screening/immunization | No charge <u>Deductible</u> does not apply. | Not Covered | <u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage. 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% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required for genetic testing. |
| | Imaging (CT/PET scans, MRIs) | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com | Tier 1 (Preferred Generic drugs) | \$5/prescription <u>Deductible</u> does not apply. | Not Covered | <u>Plan 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) | \$50/prescription <u>Deductible</u> does not apply. | Not Covered | |
| | Tier 3 (Non-Preferred Generic and Non-Preferred Brand drugs) | \$75/prescription <u>Deductible</u> does not apply. | Not Covered | |
| | Specialty drugs | 30% <u>Coinsurance</u> <u>Deductible</u> does not apply. | Not Covered | Only Brand Drugs are Covered. <u>Plan Preauthorization</u> is required. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx |
| If you have outpatient | Facility fee (e.g., ambulatory) | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> for some services is |

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| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| surgery | surgery center) | | | required. See Section 8.2.1 of your Certificate of Coverage. |
| | Physician/surgeon fees | 10% <u>Coinsurance</u> | Not Covered | |
| If you need immediate medical attention | Emergency room care | 10% <u>Coinsurance</u> | 10% <u>Coinsurance</u> | Emergency room care from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> . |
| | Emergency medical transportation | 10% <u>Coinsurance</u> | 10% <u>Coinsurance</u> | Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> . |
| | Urgent care | \$25/visit <u>Deductible</u> does not apply. | \$25/visit <u>Deductible</u> does not apply. | 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) | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.) |
| | Physician/surgeon fees | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.) |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10/visit | Not Covered | None. |
| | Inpatient services | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required for the service to be Covered. |
| If you are pregnant | Office visits | 10% <u>Coinsurance</u> | Not Covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 10% <u>Coinsurance</u> | Not Covered | |
| | Childbirth/delivery facility services | 10% <u>Coinsurance</u> | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | 10% <u>Coinsurance</u> | Not Covered | <u>Plan Preauthorization</u> is required for the service to be Covered. Housekeeping services and custodial care are excluded. |
| | Rehabilitation services | 10% <u>Coinsurance</u> | 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 |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | | | | are limited to 20 visits of the 30 maximum. <u>Plan Preauthorization</u> is required for the service to be Covered. |
| | Habilitation services | 10% <u>Coinsurance</u> | 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 visits of the 30 maximum. <u>Plan Preauthorization</u> is required for the service to be Covered. |
| | Skilled nursing care | 10% <u>Coinsurance</u> | Not Covered | 60 days annual max |
| | Durable medical equipment | 10% <u>Coinsurance</u> | Not Covered | Durable medical equipment that costs \$3,000 or more requires <u>Plan Preauthorization</u> . |
| | Hospice services | 10% <u>Coinsurance</u> | Not Covered | 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 | 10% <u>Coinsurance</u> | Not Covered | Benefit maximum: 1 eye exam per calendar year. |
| | Children's glasses | 10% <u>Coinsurance</u> | Not Covered | Benefit maximum: 1 pair of glasses per calendar year. |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered |

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"> • Abortion • 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 |
|---|--|---|

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

| | |
|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Infertility services • Weight loss programs |
|--|--|

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

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

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

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

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

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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](#) \$250
- [Specialist](#) [[cost sharing](#)] \$15
- Hospital (facility) [[cost sharing](#)] 10%
- Other [[cost sharing](#)] 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 | \$11,640 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$0 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,060 |

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [[cost sharing](#)] \$15
- Hospital (facility) [[cost sharing](#)] 10%
- Other [[cost sharing](#)] 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 | \$4,580 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$700 |
| Coinsurance | \$80 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,020 |

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist](#) [[cost sharing](#)] \$15
- Hospital (facility) [[cost sharing](#)] 10%
- Other [[cost sharing](#)] 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 | \$2,310 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$40 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$490 |