




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:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or \$7,100/individual or \$14,200/family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>\$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>\$7,100/individual or \$14,200/family (\$9,100 for an Individual in a Family)</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, the overall family <a href="#">out-of-pocket limit</a> must be met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Copayments</a> for certain services, premiums, <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See McLarenHealthPlan.org or call (888) 327-0671 for a list of <a href="#">network providers</a>.</p>	<p>This plan uses a <a href="#">provider</a> network. You will pay less if you use a provider in the <a href="#">plan's</a> network (a "<a href="#">Participating Provider</a>". You will pay the most if you use a <a href="#">non-Participating Provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">Provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware your <a href="#">Participating Provider</a> might use a <a href="#">non-Participating Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . Note, however, that some services require <a href="#">plan Preauthorization</a> 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
		In-Network I/T/U Provider	Out-of-Network I/T/U Provider	Other In-Network Providers	Out-of-Network Non-I/T/U Provider	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge <a href="#">Deductible</a> does not apply.	Provider <a href="#">Balance Bill</a>	No charge/visit	Not Covered	None.
	<a href="#">Specialist</a> visit	No charge <a href="#">Deductible</a> does not apply.	Provider <a href="#">Balance Bill</a>	No charge/visit	Not Covered	<a href="#">Plan Preauthorization</a> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Provider <a href="#">Balance Bill</a>	No charge <a href="#">Deductible</a> does not apply.	Not Covered	<a href="#">Plan Preauthorization</a> 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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge <a href="#">Deductible</a> does not apply.	Provider <a href="#">Balance Bill</a>	No charge	Not Covered	<a href="#">Plan Preauthorization</a> is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	No charge <a href="#">Deductible</a> does not apply.	Provider <a href="#">Balance Bill</a>	No charge	Not Covered	<a href="#">Plan Preauthorization</a> is required.
If you need drugs to	Generic drugs (Tier 1) –	No charge	Provider <a href="#">Balance</a>	No charge	Not Covered	<a href="#">Plan Preauthorization</a> is

[\* 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
		In-Network I/T/U Provider	Out-of-Network I/T/U Provider	Other In-Network Providers	Out-of-Network Non-I/T/U Provider	
<b>treat your illness or condition</b> More information about <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">prescription drug coverage</a> is available at <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx</a> .	Preferred Generic	<u>Deductible</u> does not apply.	<u>Bill</u>			required for some drugs. See the Plan Formulary at <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx</a>
	Preferred brand drugs (Tier 2) – Preferred Brand	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	
	Non-preferred brand drugs (Tier 3) - Non-Preferred Generic and Non- Preferred Brand	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	
	<a href="#">Specialty drugs</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Only Brand Drugs are Covered. Plan Preauthorization is required. See the Plan Formulary at <a href="http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx">http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx</a>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	<u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
	Physician/surgeon fees	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	<u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	No charge	No charge	None.
	<a href="#">Emergency medical transportation</a>	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	No charge	No charge	Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	<a href="#">Urgent care</a>	No charge <u>Deductible</u> does	No charge <u>Deductible</u> does	No charge	No charge	Urgent care from a <u>Non-Participating Provider</u> may

[\* 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
		In-Network I/T/U Provider	Out-of-Network I/T/U Provider	Other In-Network Providers	Out-of-Network Non-I/T/U Provider	
		not apply.	not apply.			result in a <u>balance bill</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.)
	Physician/surgeon fees	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	None.
	Inpatient services	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered.
<b>If you are pregnant</b>	Office visits	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	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 services	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	
	Childbirth/delivery facility services	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered. Housekeeping services and custodial care are excluded.
	<a href="#">Rehabilitation services</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum: 30 visits annual max for each.

[\* 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
		In-Network I/T/U Provider	Out-of-Network I/T/U Provider	Other In-Network Providers	Out-of-Network Non-I/T/U Provider	
						Chiropractic services are limited to 20 visits of the 30 visit maximum. <u>Plan Preauthorization</u> is required for the service to be Covered.
	<a href="#">Habilitation services</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	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.
	<a href="#">Skilled nursing care</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	60 days annual max
	<a href="#">Durable medical equipment</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Durable medical equipment that costs \$3,000 or more requires <u>Plan Preauthorization</u> .
	<a href="#">Hospice services</a>	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Inpatient hospice services require <u>Plan Preauthorization</u> . 45 days annual max for inpatient hospice services.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Benefit maximum: 1 eye exam per calendar year.
	Children's glasses	No charge <u>Deductible</u> does not apply.	Provider <u>Balance Bill</u>	No charge	Not Covered	Benefit maximum: 1 pair of glasses per calendar year.
	Children's dental check-up	Not Covered	Not Covered	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](#).)

- Abortions
- Acupuncture
- Cosmetic surgery
- Dental care (Pediatric)
- Dental care (Adult)
- 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: 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 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)-999-6442 or [DIFS-HICAP@Michigan.gov](mailto: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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,100
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	\$0
■ Other <a href="#">[cost sharing]</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$7,100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,160</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,100
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	\$0
■ Other <a href="#">[cost sharing]</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,420</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,100
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	\$0
■ Other <a href="#">[cost sharing]</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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



Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.