




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 ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
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?	Prescription drugs - \$0/individual or \$0/family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
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 .	You pay the least if you use a Participating Provider . You might receive a bill from a Non-Participating I/T/U Provider for the difference between the Provider's charge and what you plan pays (balance billing). You will pay the most if you use a non-Participating Provider/non-I/T/U 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	Non Participating I/T/U Provider	Non-Participating I/T/U Provider & 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	None.
	Specialist visit	No charge <u>Deductible</u> does not apply.	Provider balance bill	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.	Provider balance bill	Not Covered	<u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
If you have a test	Diagnostic test (x-ray, blood work)	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	<u>Plan Preauthorization</u> is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	No charge <u>Deductible</u> does not apply.	Provider balance bill	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 http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx .	Generic drugs (Tier 1) – Preferred Generic	No charge <u>Deductible</u> does not apply.	Provider balance bill	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
	Preferred brand drugs (Tier 2) – Preferred Brand	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	
	Non-preferred brand drugs (Tier 3) - Non-Preferred Generic and Non- Preferred Brand	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	
	Specialty drugs	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Only Brand Drugs are Covered. <u>Plan Preauthorization</u> is required. See the Plan Formulary at

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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 I/T/U Provider & Non-I/T/U Provider	
					http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx
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	<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 balance bill	Not Covered	<u>Plan Preauthorization</u> for some services is required. See Section 8.2.1 of your Certificate of Coverage.
If you need immediate medical attention	Emergency room care	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	None.
	Emergency medical transportation	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	Urgent care	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	Urgent care from a <u>Non-Participating Provider</u> 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	<u>Plan 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 balance bill	Not Covered	
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	<u>Plan Preauthorization</u> is required for Inpatient services other than maternity to be Covered.
	Inpatient services	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	

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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 I/T/U Provider & Non-I/T/U Provider	
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	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	
	Childbirth/delivery facility services	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	<u>Plan Preauthorization</u> is required for the service to be Covered. Housekeeping services and custodial care are excluded.
	Rehabilitation 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 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	No charge <u>Deductible</u> does	Provider balance bill	Not Covered	60 days annual max

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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 I/T/U Provider & Non-I/T/U Provider	
		not apply.			
	Durable medical equipment	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Durable medical equipment that costs \$3,000 or more requires <u>Plan Preauthorization</u> .
	Hospice services	No charge <u>Deductible</u> does not apply.	Provider balance bill	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	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Benefit maximum: 1 eye exam per calendar year.
	Children's glasses	No charge <u>Deductible</u> does not apply.	Provider balance bill	Not Covered	Benefit maximum: 1 pair of glasses per calendar year.
	Children's dental check-up	Not Covered	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"> • 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

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 	

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

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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.

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	\$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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

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	\$2,800
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In this example, Mia would pay:

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

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