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.]

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 Deductible does not apply.	Not Covered	None.
	Specialist visit	$15/visit Deductible does not apply.	Not Covered	Plan Preauthorization for some services is required. See Section 8.2.1 of your Certificate of Coverage.
	Preventive care/screening/ immunization	No charge Deductible does not apply.	Not Covered	Plan Preauthorization 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% Coinsurance	Not Covered	Plan Preauthorization is required for genetic testing.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not Covered	Plan Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs (Tier 1) – Preferred Generic	$5/prescription Deductible does not apply.	Not Covered	Plan Preauthorization 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	$50/prescription Deductible does not apply.	Not Covered	
	Non-preferred brand drugs (Tier 3) - Non-Preferred Generic and Non-Preferred Brand	$75/prescription Deductible does not apply.	Not Covered	
	Specialty drugs	30% Coinsurance Deductible does not apply.	Not Covered	Only Brand Drugs are Covered. Plan Preauthorization 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% Coinsurance	Not Covered	Plan Preauthorization for some services is

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)	
surgery	surgery center)			required. See Section 8.2.1 of your Certificate of Coverage.
	Physician/surgeon fees	10% Coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	None.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	Emergency medical transportation from a Non-Participating Provider may result in a balance bill.
	Urgent care	$25/visit Deductible does not apply.	$25/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	Not Covered	Plan Preauthorization is required for the service to be Covered (with the exception of Maternity Care.)
	Physician/surgeon fees	10% Coinsurance	Not Covered	Plan Preauthorization 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% Coinsurance	Not Covered	Plan Preauthorization is required for the service to be Covered.
If you are pregnant	Office visits	10% Coinsurance	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	10% Coinsurance	Not Covered	
	Childbirth/delivery facility services	10% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	Not Covered	Plan Preauthorization is required for the service to be Covered. Housekeeping services and custodial care are excluded.
	Rehabilitation services	10% Coinsurance	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. Plan Preauthorization is required for the

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)	
				service to be Covered.
If you need help recovering or have other special health needs	Habilitation services	10% Coinsurance	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. Plan Preauthorization is required for the service to be Covered.
	Skilled nursing care	10% Coinsurance	Not Covered	60 days annual max
	Durable medical equipment	10% Coinsurance	Not Covered	Durable medical equipment that costs $3,000 or more requires Plan Preauthorization.
	Hospice services	10% Coinsurance	Not Covered	Inpatient hospice services require Plan Preauthorization. 45 days annual max for inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	10% Coinsurance	Not Covered	Benefit maximum: 1 eye exam per calendar year.
	Children's glasses	10% Coinsurance	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.)

- Abortion
- 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

[* 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, kwiijigo holne' (888) 327-0671.]

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

[* For more information about limitations and exceptions, see the plan or policy document at McLarenHealthPlan.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** **$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$800
What isn't covered	
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$700
Coinsurance	$50
What isn't covered	
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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