




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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	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> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See McLarenHealthPlan.org or call (888) 327-0671 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">Participating Provider</a> . You might receive a bill from a <a href="#">Non-Participating I/T/U Provider</a> for the difference between the <a href="#">Provider's</a> charge and what you <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). You will pay the most if you use a <a href="#">non-Participating Provider/non-I/T/U 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 you <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.
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
		Participating Provider	Non Participating I/T/U Provider	Non-Participating I/T/U Provider & Non-I/T/U Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge <u>Deductible</u> does not apply; No Charge for Virtual Visits.	Provider balance bill	Not Covered	None. Virtual Visits are limited to treatment received through McLaren Now.
	<a href="#">Specialist</a> 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.
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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.
<b>If you need drugs to 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> .	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 <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 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	
	<a href="#">Specialty drugs</a>	No charge	Provider balance	Not Covered	Only Brand Drugs are 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	
		<u>Deductible</u> does not apply.	bill		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>
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	<a href="#">Emergency room care</a>	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.
	<a href="#">Emergency medical transportation</a>	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> .
	<a href="#">Urgent care</a>	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; No Charge for Virtual	Provider balance bill	Not Covered	None. Virtual Visits are limited to those specified in your Certificate of Coverage.

[\* 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 I/T/U Provider & Non-I/T/U Provider	
		Visits.			
	Inpatient 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.
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	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	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

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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	
					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 balance bill	Not Covered	60 days annual max
	<a href="#">Durable medical equipment</a>	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> .
	<a href="#">Hospice services</a>	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.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortions</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Pediatric)</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility services</li> <li>• Weight loss programs</li> </ul>

**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

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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.*

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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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

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

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

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

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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

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.

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