McLaren Health Plan Community: McLaren Small Group Bronze **Coverage Period: 1/1/2017 – 12/31/2017**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for**: Single, Single + Spouse or Family | **Plan Type: HMO**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to McLarenHealthPlan.org or call 1-888-327-0671. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other bolded terms see the Glossary. You can view the Glossary at McLarenHealthPlan.org or call 1-888-327-0671 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 5,000 Person/ $ 10,000 Family Does not apply to **preventive care**, **prescription drugs**, or other services that have a flat dollar **Copayment**.	You must pay all of the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). The Common Medical Events chart below shows how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
Is there an out–of–pocket limit on my expenses?	Yes $ 7,150 Person/ $ 14,300 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits
Does this plan use a network of providers?	Yes. See **McLarenHealthPlan.org or call 1-888-327-0671** for a list of participating **providers**.	If you use an in-network health care **provider**, this **plan** will pay some or all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-network providers. Be aware, your in-network doctor or hospital may use another out-of-network **provider** for some services (such as lab work).
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the **plan**'s permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services

Questions: Call 1-888-327-0671 or visit us at www.McLarenHealthPlan.com. If you aren't clear about any of the underline terms used in this form, see the Glossary. You can view the Glossary at www.McLarenHealthPlan.com or call 1-888-327-0671 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital say is $1,00, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference (This is called **balance billing**.)
- This plan may encourage you to use In-Network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use Providers		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	% 50 Coinsurance and Deductible	Not covered	-- None --
	Specialist visit	% 50 Coinsurance and Deductible	Not covered	-- None --
	Other practitioner office visit	% 50 Coinsurance and Deductible	Not covered	-- None --
	Preventive care/ screening/immunization	No charge	Not covered	-- None --
If you have a test	Diagnostic test (x-ray, blood work)	% 50 Coinsurance and Deductible	Not covered	-- None --
	Imaging (CT/PET scans, MRIs)	% 50 Coinsurance and Deductible	Not covered	Requires plan preauthorization or service is not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mclaren-healthplan.org/Mc-LarenHealthPlan/ForourCommer-cialMembersmhp.aspx.**	Preventive drugs	No charge	Not covered	Covers up to a 30-day supply (retail prescription)
	Preferred generic drugs	$ 30 Copay/ Prescription (Retail)	Not covered	Covers up to a 30-day supply (retail prescription)
	Preferred brand drugs	$ 70 Copay/ Prescription (Retail)	Not covered	Covers up to a 30-day supply (retail prescription)
	Non-preferred brand drugs and non-preferred generic	$ 200 Copay/ Prescription (Retail)	Not covered	Covers up to a 30-day supply (retail prescription)
	Specialty drugs	$ 300 Copay/ Prescription	Not covered	Covers up to a 30-day supply (specialty pharmacy)

Common Medical Event	Services You May Need	Your Cost if You Use Providers		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
	Physician/surgeon fees	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
If you need immediate medical attention	Emergency room services	% 50 Coinsurance and Deductible	% 50 Coinsurance and Deductible	For out-of-network services, you are responsible for any **balance billing.**
	Emergency medical transportation	% 50 Coinsurance and Deductible	% 50 Coinsurance and Deductible	For out-of-network services, you are responsible for any **balance billing**.
	Urgent care	% 50 Coinsurance and Deductible	% 50 Coinsurance and Deductible	For out-of-network services, you are responsible for any **balance billing.**
If you have a hospital stay	Facility fee (e.g., hospital room)	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
	Physician/surgeon fee	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	% 50 Coinsurance and Deductible	Not covered	-- None --
	Mental/Behavioral health inpatient services	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
	Substance use disorder outpatient services	% 50 Coinsurance and Deductible	Not covered	-- None --
	Substance use disorder inpatient services	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.

Common Medical Event	Services You May Need	Your Cost if You Use Providers		Limitations & Exceptions
		In-Network	Out-of-Network	
If you are pregnant	Prenatal and postnatal care	Prenatal office visits – no charge All other maternity care – % 50 Coinsurance and Deductible	Not covered	-- None --
	Delivery and all inpatient services	% 50 Coinsurance and Deductible	Not covered	-- None --
If you need help recovering or have other special health needs	Home health care	% 50 Coinsurance and Deductible	Not covered	-- None --
	Rehabilitation services	% 50 Coinsurance and Deductible	Not covered	Limited to 30 visits/condition/year. Requires **plan preauthorization** or service is not covered.
	Habilitation services	% 50 Coinsurance and Deductible	Not covered	Limited to 30 visits/condition/year. ABA treatment for autism has no annual limit. All require **plan preauthorization** or service is not covered.
	Skilled nursing care	% 50 Coinsurance and Deductible	Not covered	Limited to 60 days/year. Requires **plan preauthorization** or service is not covered.
	Durable medical equipment	% 50 Coinsurance and Deductible	Not covered	Items costing $3000 or more require **plan preauthorization** or item is not covered.
	Hospice service	% 50 Coinsurance and Deductible	Not covered	Requires **plan preauthorization** or service is not covered.
If your child needs dental or eye care	Eye exam	% 50 Coinsurance and Deductible	Not covered	Limited to one exam per year
	Glasses	% 50 Coinsurance and Deductible	Not covered	Limited to one pair of glasses per year
	Dental check-up	Not covered	Not covered	-- None --

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Abortions (voluntary) • Acupuncture • Cosmetic surgery • Dental care	• Glasses for Adults • 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment • Weight loss programs	

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-327-0671. You may also contact your state insurance department at the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for **claims** under your **plan**, you may be able to **appeal** or file a **grievance**. 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 Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard? Yes. This coverage constitutes minimum essential coverage under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the **individual responsibility requirement**. In addition, this health coverage is designed to pay at least 60% of the total cost of certain essential medical services."

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

About these Coverage Examples:

These examples show how this plan might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Patient Pays" section for the same example under each plan's Summary of Benefits and Coverage.

Having a baby
(normal delivery)

☑ Cost of care	$7,540
☑ Plan pays	$1,240
☑ Patient pays	$6,300

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$5,000
Copays	$20
Coinsurance	$1,130
Limits or exclusions	$150
Total	$6,300

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

☑ Cost of care	$5,400
☑ Plan pays	$160
☑ Patient pays	$5,240

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$5,000
Copays	$90
Coinsurance	$70
Limits or exclusions	$80
Total	$5,240

This is not a cost estimator.
Don't use these examples to estimate your actual costs under this plan. Treatments shown are just examples and your actual care you receive, the prices your providers charge, and many other factors.
Also, costs don't include premiums you pay to buy coverage under a plan.

Note: The numbers in "Managing type 2 diabetes" assume the patient is participating in the plan's diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: Customer Service Department (888) 327-0671.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example Show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayment,** and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not **cost** estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Can I use Coverage Examples to compare plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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