




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, [insert contact information]. 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 [www.\[insert\].com](#) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 1,800/individual or \$3,600/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes	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 cot-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 ?	\$6,000/individual or \$12,000/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 ?	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 1-800-0671 for a list of network providers .	You pay the least if you use a Rewards Participating Provider . You pay more if you use a Participating Provider in the standard network. 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 you 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		Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)			
		Rewards	Non-Rewards		
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge <u>Deductible</u> does not apply.	\$40/visit <u>Deductible</u> does not apply.	Not Covered	<u>Plan Preauthorization</u> for some services is required. See Section 8.02.01 of your Certificate of Coverage. <u>Plan Preauthorization</u> for some services is required. See Section 8.02.01 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.
	<u>Specialist</u> visit		\$60/visit <u>Deductible</u> does not apply.		
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.			
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>Deductible</u> does not apply.	25% <u>Coinsurance</u>	Not Covered	<u>Plan Preauthorization</u> is required for genetic testing. <u>Plan Preauthorization</u> is required.
	Imaging (CT/PET scans, MRIs)		25% <u>Coinsurance</u>		
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.[insert].com	Tier 1 (Generic drugs)	No charge <u>Deductible</u> does not apply.	\$20/ prescription <u>Deductible</u> does not apply.	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
	Tier 2 (Preferred brand drugs)		\$60/ prescription <u>Deductible</u> does not apply.		
	Tier 3 (Non-preferred brand drugs)		\$250/ prescription <u>Deductible</u> does not apply.		
	<u>Specialty drugs</u>		\$350/ prescription <u>Deductible</u> does not apply.		Only Brand Drugs are Covered. Plan Preauthorization is required. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx

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)	
		Rewards	Non-Rewards		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge <u>Deductible</u> does not apply.	25% <u>Coinsurance</u>	Not Covered	Plan <u>Preauthorization</u> for some services is required. See Section 8.02.01 of your Certificate of Coverage.
	Physician/surgeon fees		25% <u>Coinsurance</u>		
If you need immediate medical attention	Emergency room care	No charge <u>Deductible</u> does not apply.	\$400/visit <u>Deductible</u> does not apply.	\$400/visit <u>Deductible</u> does not apply.	Emergency room care from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	Emergency medical transportation		25% <u>Coinsurance</u>	25% <u>Coinsurance</u>	Emergency medical transportation from a <u>Non-Participating Provider</u> may result in a <u>balance bill</u> .
	Urgent care		\$60/visit <u>Deductible</u> does not apply.	\$60/visit <u>Deductible</u> does not apply.	Urgent care from a Non-Participating Provider 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.	25% <u>Coinsurance</u>	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered (with the exception of Maternity Care.)
	Physician/surgeon fees		25% <u>Coinsurance</u>		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge <u>Deductible</u> does not apply.	\$40/visit <u>Deductible</u> does not apply	Not Covered	Plan <u>Preauthorization</u> is required for the service to be Covered.
	Inpatient services		25% <u>Coinsurance</u>		
If you are pregnant	Office visits	No charge <u>Deductible</u> does not apply.	25% <u>Coinsurance</u>	Not Covered	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services		25% <u>Coinsurance</u>		
	Childbirth/delivery facility services		25% <u>Coinsurance</u>		
If you need help recovering or have other special health needs	Home health care	No charge <u>Deductible</u> does not apply.	25% <u>Coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)			
		Rewards	Non-Rewards		
If you need help recovering or have other special health needs	Rehabilitation services	No charge <u>Deductible</u> does not apply.	25% <u>Coinsurance</u>	Not Covered	Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum: 30 visits annual max for each. <u>Plan Preauthorization</u> is required for the service to be Covered.
	Habilitation services		25% <u>Coinsurance</u>		Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum; 30 visits annual max for each. <u>Plan Preauthorization</u> is required for the service to be Covered.
	Skilled nursing care		25% <u>Coinsurance</u>		60 days annual max
	Durable medical equipment		25% <u>Coinsurance</u>		Durable medical equipment that costs \$3,000 or more requires <u>Plan Preauthorization</u> .
	Hospice services		25% <u>Coinsurance</u>		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.	25% <u>Coinsurance</u>	Not Covered	Benefit maximum: 1 eye exam per calendar year.
	Children's glasses		25% <u>Coinsurance</u>		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](#).)

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|--|--|---|
| <ul style="list-style-type: none">• 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 |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|
| <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 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#).

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

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	\$1800
■ Specialist [<i>cost sharing</i>]	\$60
■ Hospital (facility) [<i>cost sharing</i>]	25%
■ Other [<i>cost sharing</i>]	25%

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:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$200
Coinsurance	\$3,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,160

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1800
■ Specialist [<i>cost sharing</i>]	\$60
■ Hospital (facility) [<i>cost sharing</i>]	25%
■ Other [<i>cost sharing</i>]	25%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$1,800
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,760

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1800
■ Specialist [<i>cost sharing</i>]	\$60
■ Hospital (facility) [<i>cost sharing</i>]	25%
■ Other [<i>cost sharing</i>]	25%

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$1,400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

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