This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mclarenhealthplan.org or by calling 1-888-327-0671.

Important Questions	Option A Answers	Option B Answers	Why this Matters:
What is the overall deductible?	$125 per person $250 per family	$250 per person $500 per family	Except for services requiring a fixed dollar co-payment, you must pay all 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 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No		You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes $2000 per person $4000 per family	Yes $2000 per person $4000 per 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**. Co-insurance payments do 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 **www.mclarenhealthplan.org or call 1-888-327-0671** for a list of participating providers.		If you use an in-network participating doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or **participating** for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		In some cases obtaining services without a referral will result in increased cost sharing.
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**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the 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 stay is $1,000, your **co-insurance** 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost Using Participating Providers	Your Cost Using Non-participating Providers	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Specialist visit	$20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Other practitioner office visit	$20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Preventive care, screenings, immunizations	No charge	30% co-insurance, plus balance billing	Immunizations are not covered when provided by an non-participating provider
If you have a test	Diagnostic test (x-ray, blood work)	After deductible, Covered at 100%	30% co-insurance, plus balance billing	Pre-authorization required
	Imaging (CT/PET scans, MRIs)	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mclarenhealthplan.org.	Generic drugs	Retail - $10 Co-pay/prescription Mail order - $20 Co-pay/prescription		----------None----------
	Formulary drugs	Retail - $30 Co-pay/prescription Mail order - $60 Co-pay/prescription		----------None----------
	Non-formulary drugs	Retail - $60 Co-pay/prescription Mail order - $120 Co-pay/prescription		Pre-authorization or Step Therapy required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required

Common Medical Event	Services You May Need	Your Cost Using Participating Providers	Your Cost Using Non-participating Providers	Limitations & Exceptions
	Physician/surgeon fees	After deductible, Covered at 100%	20% Co-insurance, plus balance billing No coverage for special surgical procedures	Pre-authorization required
If you need immediate medical attention	Emergency room services	$200 Co-pay/visit Waived if admitted to hospital.	$200 Co-pay/visit Waived if admitted to hospital.	For emergency room services provided by a **non-participating provider** you may be responsible for **balance billing**.
	Emergency medical transportation	After deductible, Covered at 100%	After deductible, Covered at 100%	----------None----------
	Urgent care	$20 Co-pay/visit	$20 Co-pay/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required
	Physician/surgeon fees	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required *Excludes expenses related to special surgical procedures.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Mental/Behavioral health inpatient services	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required
	Substance use disorder outpatient services	$20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Substance use disorder inpatient services	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	Pre-authorization required
If you are pregnant	Prenatal Care Postnatal Care	No Charge $20 Co-pay/visit	30% co-insurance, plus balance billing	----------None----------
	Delivery and all inpatient services	After deductible, Covered at 100%	20% Co-insurance, plus balance billing	----------None----------
If you need help recovering or have other special health needs	Home health care	After deductible, Covered at 100%	Not Covered	Pre-authorization required Limited to 60 days per episode per year

Common Medical Event	Services You May Need	Your Cost Using Participating Providers	Your Cost Using Non-participating Providers	Limitations & Exceptions
	Rehabilitation services	$20 Co-pay, Maximum of 90 visits	20% Co-insurance, plus balance billing Maximum of 90 visits	Pre-authorization required
	Habilitation services	Not Covered	Not Covered	----------None----------
	Skilled nursing care	After deductible, Covered at 100%	Not Covered	Pre-authorization required
	Durable medical equipment	After deductible, Covered at 100%	Not Covered	Pre-authorization required
	Hospice service	After deductible, Covered at 100%	Not Covered	Pre-authorization required
If your child needs dental or eye care	Eye exam	$20 Co-pay/visit	Not Covered	----------None----------
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside The U.S.
- Weight loss programs

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
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-327-0671. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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 questions about your rights, this notice, or assistance, you can contact: McLaren Health Plan, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also contact the Employee Benefits Security Administration at (866) 444-3272 or www.dol.gob/ebsa/healthreform.com and/or the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877)999-6442 or DIFS-HICAP@michigan.gov .

Does this Coverage Provide Minimum Essential Coverage:

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard:

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtenerasistencia en Español, llame al (888) 327-0671.

Tagalog (Tagalog): Kung kailanganninyoangtulongsa Tagalog tumawagsa(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'ehgoshikaat'ohwolninisingo, kwiijigoholne' (888) 327-0671.

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 given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,240
- **Patient pays** $ 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	$130
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$300**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,590
- **Patient pays** $810

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	$130
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$810**

Note: These numbers assume the patient has given notice of her pregnancy to the plan and has obtained preauthorization for the hospital stay. If you are pregnant and have not given notice or obtained a preauthorization, your cost may be higher. For more information please contact customer service at 1-888-327-0671.

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 **participating providers**. If the patient had received care from **non-participating providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** 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.

Are there other costs I should consider when comparing 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 **co-payments**, **deductibles**, and **co-insurance**. 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.