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 1-888-327-0671. 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 1-888-327-0671 to request a copy.

Important Questions	Option A Answers	Option B Answers	Why This Matters:
What is the overall deductible?	$0 / individual $0 / family	$0 / individual $0 / 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 is covered before you meet your deductible.	No	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	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000/individual $4,000/family	$2,000/individual $4,000/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 www.McLarenHealthPlan.org or call 1-888-327-0671 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. You will pay the most if you use an out-of-network 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 network provider might use an out-of-network 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.

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
		Network Provider (You will pay the least)	Out-of-Network 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	$20 copay/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Specialist visit	$20 copay/visit Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Preventive care/screening/ immunization	No charge Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance plus balance bill	Plan preauthorization is required for genetic testing. See Section 8.05.01 of your Certificate of Coverage. Deductible does not apply to Laboratory Services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MclarenHealthPlan.org.	Generic drugs (Tier 1)	Retail - $10/prescription (up to a 90-day supply for 1 copay) Mail order - $20/prescription (90-day supply) Deductible does not apply.		Preauthorization is required for some drugs. See the plan formulary at https://www.mclarenhealthplan.org/community-member/formulary-lookup-large-mhp.
	Preferred brand drugs (Tier 2)	Retail - $30/prescription (34-day supply) Mail order - $60/prescription (90-day supply) Deductible does not apply.		
	Non-preferred brand drugs (Tier 3)	Retail - $60/prescription (34-day supply) Mail order - $120/prescription (90-day supply) Deductible does not apply.		

* For more information about limitations and exceptions, see the plan or policy document at www.mclarenhealthplan.org/community-member/mclaren-connect.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	No charge	20% coinsurance plus balance bill	
If you need immediate medical attention	Emergency room care	$200 copay/visit Deductible does not apply.	$200 copay/visit Copay waived if admitted.	You may be responsible for a balance bill when services are obtained by non-participating providers. Copay waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$20 copay/visit Deductible does not apply.	$20 copay/visit Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance plus balance bill	Plan preauthorization is required for the service to be covered (with the exception of Maternity Care). See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	No charge	20% coinsurance plus balance bill	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Inpatient services	No charge	20% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
If you are pregnant	Office visits	No charge Deductible does not apply.	30% coinsurance plus balance bill	Cost sharing does not apply for preventive services. Depending on the type of services, copay or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance plus balance bill	
	Childbirth/delivery facility services	No charge	20% coinsurance plus balance bill	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$20 copay	Not covered	Limited to 60 days per episode per calendar year.
	Rehabilitation services	$20 copay/visit Deductible does not apply.	20% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. Combined max of 90 visits per calendar year for all services, Physical and Occupational Therapy Disorder and Speech Therapy Treatments, except ABA for treatment of Autism.
	Habilitation services	$20 copay Deductible does not apply.	20% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. 30 visits per year for habilitation services, except ABA Treatment for Autism, No charge
	Skilled nursing care	No charge	Not covered	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. Up to 120 days per confinement.
	Durable medical equipment	No charge Deductible does not apply.	Not covered	Durable medical equipment that costs $3,000 or more requires plan preauthorization. See Section 8.05.01 of your Certificate of Coverage.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$20 copayment for medical exams	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Hearing aids
- Infertility Treatment
- Private Duty Nursing

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: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: McLaren Health Plan Community, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also 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.

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.

Language Access Services:

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-0671-327-888 (رقم هاتف الصم والبكم:).

Syriac/Assyrian: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܡܠܠܐ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܬܡܨܝܢ ܕܬܫܬܡܫ ܒܚܠܡܬܐ ܕܥܘܕܪܐ ܒܠܫܢܐ ܡܓܢ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671 （TTY：711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711)

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	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$140**

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 copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$955**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	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*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$140**

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