The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 (In-Network) Answers	Option B (Out-of-Network) Answers	Why This Matters:
What is the overall deductible?	\$125/individual \$250/individual \$250/family		Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	No	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$2,000/individual \$4,000/family	\$2,000/individual \$4,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?		billing charges and lan 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 <u>network provider</u> ?	Yes. See www.McLarenHealthPlan.org or call 1-888-327-0671 for a list of network providers .		This <u>plan</u> uses a provider network. You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	N	lo	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You	ı Will Pay	Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> <u>Deductible</u> does not apply.	30% <u>coinsurance</u> plus <u>balance bill</u>	None
If you visit a health care	Specialist visit	\$20 <u>copay</u> <u>Deductible</u> does not apply.	30% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization for some services is required. See Section 8.02.01 of your Certificate of Coverage.
provider's office or clinic	Preventive care/screening/ immunization	No charge Deductible does not apply.	30% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization is required for genetic testing. See Section 8.02.01 of your Certificate of Coverage. Deductible does not apply to Laboratory Services.
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization is required. See Section 8.02.01 of your Certificate of Coverage.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail – \$10/ <u>copay</u> (34-day supply) Mail order – \$20/ <u>copay</u> (90-day supply) <u>Deductible</u> does not apply.		Preauthorization is required for some drugs. See the plan formulary at
More information about prescription drug coverage is available at	Preferred brand drugs (Tier 2)	Retail – \$30/ <u>copay</u> (34-day supply) Mail order – \$60/ <u>copay</u> (90-day supply) <u>Deductible</u> does not apply.		https://www.mclarenhealthplan.org/community-member/formulary-lookup-largemhp. After initial fill, member can obtain
www.MclarenHealthPlan. org	Non-preferred brand drugs (Tier 3)	Retail – \$60/ <u>copay</u> (34-day supply) Mail order – \$120/ <u>copay</u> (90-day supply) <u>Deductible</u> does not apply.		up to a 90-day supply for 1 copay for most tier 1 medications

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.mclarenhealthplan.org/community-member/mclaren-connect.</u> Page 2 of 7

		What Yo	u Will Pay	Limitations, Exceptions, & Other	
Common Medical Event	Common Medical Event Services You May Need		Out-of-Network Provider (You will pay the most)	Important Information	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance plus, balance bill	Plan preauthorization for some services	
surgery	Physician/surgeon fees	No charge	20% coinsurance plus, balance bill	is required. See Section 8.02.01 of your Certificate of Coverage.	
	Emergency room care	\$200 <u>copay</u> <u>Deductible</u> does not apply.	\$200 copay Deductible does not apply.	\$0 <u>copay</u> for McLaren Now (virtual)	
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	urgent care visits, www.mclarennow.org.	
	<u>Urgent care</u>	\$20 <u>copay</u>	\$20 <u>copay</u>	Copay waived if admitted as inpatient.	
If you have a hospital	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	
stay	Physician/surgeon fees	No charge	20% <u>coinsurance</u> plus <u>balance bill</u>	Section 8.02.01 of your Certificate of Coverage.	
If you need mental health, behavioral health, or	Outpatient services	\$20 <u>copay</u> <u>Deductible</u> does not apply.	30% <u>coinsurance</u> plus <u>balance bill</u>	\$10 copay for virtual visits.	
substance abuse services	Inpatient services	No charge	20% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization for some services is required. See Section 8.02.01 of your Certificate of Coverage.	
	Office visits	\$20 <u>copay</u> <u>Deductible</u> does not apply.	30% coinsurance plus balance bill		
If you are pregnant	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u> plus <u>balance bill</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).	
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u> plus <u>balance bill</u>		

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.mclarenhealthplan.org/community-member/mclaren-connect.</u> Page 3 of 7

	What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Home health care	\$20 <u>copay</u>	Not covered	Limited to 60 days per episode per calendar year.
	Rehabilitation services	\$20 <u>copay</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization is required. See Section 8.02.01 of your Certificate of Coverage. Combined max of 90 visits per year for all services, Physical and Occupational Therapy Disorder and Speech Therapy Treatments, except ABA for treatment of Autism.
If you need help recovering or have other special health needs	Habilitation services	\$20 <u>copay</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u> plus <u>balance bill</u>	Plan preauthorization is required. See Section 8.02.01 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 8.02.01 of your Certificate of Coverage. Up to 120 days per confinement.
	Durable medical equipment	No charge <u>Deductible</u> does not apply.	Not covered	Durable medical equipment that costs \$3,000 or more requires plan preauthorization. See Section 8.02.01 of your Certificate of Coverage.
	Hospice services	No charge	Not covered	None
If your child needs dental	Children's eye exam	\$20 <u>copay</u> <u>Deductible</u> does not apply.	Not covered	Medical eye exam only.
or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.mclarenhealthplan.org/community-member/mclaren-connect.</u> Page 4 of 7

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

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.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.mclarenhealthplan.org/community-member/mclaren-connect.</u> Page 5 of 7

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:

Syriac/Assyrian:

ملحوظة :إذا لئات نتحدث اذكر الاغة، فإن خدمات المساعدة اللغوية تنولغر لك بالمجان .انصل برقم 888-327-0671-1)رقم هائف الصم والبكم: 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 কর**ুন**ঃ যদি আপান বাটাংলা, কথা বলত**ে প**াতেন, োহতল দনঃখ**ে**চায় ভাষা সহায়ো পদতেষবা উপলব্ধ আতে। ছ**ান ক**রুন ১-

888-327-0671 (TTY: 711) I

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 <u>plan</u> might cover costs for a sample medical situation, see the next section.

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^{*} For more information about limitations and exceptions, see the plan or policy document at www.mclarenhealthplan.org/community-member/mclaren-connect. Page 6 of 7

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$125
■ 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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$125	
<u>Copayments</u>	\$80	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$265	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$125
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$125
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	0%
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$125	
<u>Copayments</u>	\$140	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$265	