**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, visit us at mclarenhealthplan.org or call Customer Service at (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 (888) 327-0671 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP;<br>**Rewards:** $2,000 / individual or $4,000 / family<br>**Non-Rewards:** $8,000 / individual or $16,000 / family<br>*All amounts applied to a Deductible, regardless of Rewards or Non-Rewards will apply to both the Rewards and Non-Rewards Deductibles | 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 family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, the deductible doesn't apply to preventive care, and certain services subject to flat dollar copayments. | 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?** | Yes. Prescription Drugs:<br>$0 / individual or<br>$0 / family | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $8,250 / individual or<br>$16,500 / 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** | Yes. See mclarenhealthplan.org or | This plan uses a provider network. You pay the least if you use a Rewards provider. You pay |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **use a network provider?** | call (888) 327-0671 for a list of network providers. | more if you use a provider in the plan's network that is not a Rewards provider (a "Participating Provider". 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 your 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. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
Native American limited plans have zero cost-sharing when you see an IHCP provider or with IHCP referral to a non-IHCP provider.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Rewards Provider (You will pay the least) | Participating Provider (You will pay more) | Non-Participating 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 | No charge after Rewards Deductible | 50% coinsurance | Not covered | None. Cost sharing waived at non-IHCP with IHCP referral. |
| | Specialist visit | No charge after Rewards Deductible | 50% coinsurance | Not covered | Plan Preauthorization for some services is required. See Section 8.2.1 of your Certificate of Coverage. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Preventive care/screening/ immunization | No charge Deductible does not apply | No charge Deductible does not apply | Not covered | Plan Preauthorization for some services is required. See Section 8.2.1 of your Certificate of Coverage. The penalty for not having prior authorization is denial of payment. 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. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge after Rewards | 50% coinsurance | Not covered | Plan Preauthorization is required for genetic testing. The penalty for not having prior |

[* For more information about limitations and exceptions, see the plan or policy document at McLarenHealthPlan.org.]

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Rewards Provider (You will pay the least) | Participating Provider (You will pay more) | Non-Participating Provider (You will pay the most) | |
| | | Deductible | | | authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Imaging (CT/PET scans, MRIs) | No charge after Rewards Deductible | 50% coinsurance | Not covered | Plan Preauthorization is required. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx | Generic drugs – Tier 1 (Preferred Generic drugs) | $10 / prescription Deductible does not apply | $10 / prescription Deductible does not apply | Not covered | Plan Preauthorization is required for some drugs. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx<br><br>A 90-day supply of Brand Name Drugs or Generic Drugs may be dispensed from a Mail Order or Retail Pharmacy if a Member successfully completes a 30-day trial of the Drug. If a copayment applies, the 90-day supply may be obtained with two Copayments.<br><br>The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Preferred brand drugs – Tier 2 (Preferred brand drugs) | $85 / prescription Deductible does not apply | $85 / prescription Deductible does not apply | Not covered | |
| | Non-preferred brand drugs – Tier 3 (Non-preferred generic and non-preferred brand drugs) | 50% coinsurance Deductible does not apply | 50% coinsurance Deductible does not apply | Not covered | |
| | Specialty drugs | 50% coinsurance Deductible does not apply | 50% coinsurance Deductible does not apply | Not covered | Only Brand Drugs are Covered. Plan Preauthorization is required. See the Plan Formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have outpatient** | Facility fee (e.g., | No charge after | 50% | Not covered | Plan Preauthorization for some services is |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Rewards Provider (You will pay the least) | Participating Provider (You will pay more) | Non-Participating Provider (You will pay the most) | |
| **surgery** | ambulatory surgery center) | Rewards Deductible | coinsurance | | required. See Section 8.2.1 of your Certificate of Coverage. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge after Rewards Deductible | 50% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | No charge after Rewards Deductible | 50% coinsurance | 50% coinsurance | None. Cost sharing waived at non-IHCP with IHCP referral. |
| | Emergency medical transportation | No charge after Rewards Deductible | 50% coinsurance | 50% coinsurance | Emergency medical transportation from a Non-Participating Provider may result in a balance bill. Cost sharing waived at non-IHCP with IHCP referral. |
| | Urgent care | No charge after Rewards Deductible | 50% coinsurance | 50% coinsurance | Urgent care from a Non-Participating Provider may result in a balance bill. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge after Rewards Deductible | 50% coinsurance | Not covered | Plan Preauthorization is required for the service to be Covered (with the exception of Maternity Care.) The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge after Rewards Deductible | 50% coinsurance | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge after Rewards Deductible | 50% coinsurance | Not covered | None. Cost sharing waived at non-IHCP with IHCP referral. |
| | Inpatient services | No charge after Rewards Deductible | 50% coinsurance | Not covered | Plan Preauthorization is required for the service to be Covered. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| **If you are pregnant** | Office visits | No charge Deductible does | No charge Deductible does | Not covered | Cost sharing does not apply for preventive services. Maternity care may include tests and |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Rewards Provider (You will pay the least) | Participating Provider (You will pay more) | Non-Participating Provider (You will pay the most) | |
| | | not apply | not apply | | services described elsewhere in the SBC (i.e. ultrasound.) Cost sharing waived at non-IHCP with IHCP referral. |
| | Childbirth/delivery professional services | No charge after Rewards Deductible | 50% coinsurance | Not covered | |
| | Childbirth/delivery facility services | No charge after Rewards Deductible | 50% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge after Rewards Deductible | 50% coinsurance | Not covered | Plan Preauthorization is required for the service to be Covered. Housekeeping services and custodial care are excluded. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Rehabilitation services | No charge after Rewards Deductible | 50% coinsurance | Not covered | Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum; 30 visits annual max for each. Plan Preauthorization is required for the service to be Covered. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Habilitation services | No charge after Rewards Deductible | 50% coinsurance | Not covered | Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum; 30 visits annual max for each. Plan Preauthorization is required for the service to be Covered. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Skilled nursing care | No charge after Rewards Deductible | 50% coinsurance | Not covered | 45 days annual max. Cost sharing waived at non-IHCP with IHCP referral. |

[* For more information about limitations and exceptions, see the plan or policy document at McLarenHealthPlan.org.]

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Rewards Provider (You will pay the least) | Participating Provider (You will pay more) | Non-Participating Provider (You will pay the most) | |
| | Durable medical equipment | No charge after Rewards Deductible | 50% coinsurance | Not covered | Durable medical equipment that costs $3,000 or more requires Plan Preauthorization. The penalty for not having prior authorization is denial of payment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Hospice services | No charge after Rewards Deductible | 50% coinsurance | Not covered | Inpatient hospice services require Plan Preauthorization. The penalty for not having prior authorization is denial of payment. 45 days annual max for inpatient hospice services. Cost sharing waived at non-IHCP with IHCP referral. |
| **If your child needs dental or eye care** | Children's eye exam | No charge Deductible does not apply | No charge Deductible does not apply | Not covered | Benefit maximum: 1 eye exam per calendar year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Children's glasses | No charge Deductible does not apply | No charge Deductible does not apply | Not covered | Benefit maximum: 1 pair of glasses per calendar year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Children's dental check-up | Not covered | 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Bariatric surgery
- Chiropractic care
- Infertility services
- Routine eye care (Adult)
- 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

[* For more information about limitations and exceptions, see the plan or policy document at McLarenHealthPlan.org.]

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 on how 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) 999-6442 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.

**Language Access Services:**

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (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'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 327-0671.

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



[* For more information about limitations and exceptions, see the plan or policy document at McLarenHealthPlan.org.]

## 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** | **$8,000** |
| **Specialist coinsurance** | **50%** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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* | |
|---|---|
| Deductibles | $8000 |
| Copayments | $0 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8310** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$8,000** |
| **Specialist coinsurance** | **50%** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1900 |
| Copayments | $1200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3120** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$8,000** |
| **Specialist coinsurance** | **50%** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2800 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2810** |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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