

Employer Contribution to HRA Small Group	Plan Year		2018	
Category Service In Network MHPC Directly Contracted Out of Network	Plan Name		Gold HRA 4500 Plan	
Category Service In Network MHPC Directly Contracted Out of Network	Market		Small Group	
Category Service MHPC Directly Contracted Out of Network	Employer Contribution to HRA		\$500	
Individual Deductible \$4,500 Not Applicable	Category	Service	In Network	Out of Network
Family Deductible \$9,000 Not Applicable And Applicable Individual OOP Max \$6,5550 Not Applicable Individual OOP Max \$6,5550 Not Applicable Family OOP Max \$13,100 Not Applicable Applicable Family OOP Max \$13,100 Not Applicable App			MHPC Directly Contracted	
Member's Coinsurance 30% Not Applicable	General Plan Information	Individual Deductible	\$4,500	Not Applicable
Individual OOP Max		•	\$9,000	Not Applicable
Family OOP Max Silication				Not Applicable
Preventive Care Preventive Care/Screening/Immunization Well Baby Visits and Care Primary Care Visit to Treat an Injury or Illness Specialist Visit Mental/Behavioral Health Outpatient Services Substance Abuse Disorder Outpatient Services Other Practitioner Office Visit Emergency Care Emergency Care Laboratory and Imaging Laboratory and Imaging Maternity Care Maternity Care Hospital - Outpatient Preventive Care/Screening/Immunization No Charge Not Covered Not Covered Not Covered Not Covered Not Covered Substance Abuse Disorder Outpatient Services Substance After Deductible Substance After Deductible Substance After Deductible Not Covered Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Substance After Deductible Not Covered Not Co		Individual OOP Max	\$6,550	Not Applicable
Privative Care Well Baby Visits and Care No Charge Not Covered		•	\$13,100	Not Applicable
Well Baby Visits and Care Primary Care Visit to Treat an Injury or Illness Specialist Visit Office Visits Mental/Behavioral Health Outpatient Services Substance Abuse Disorder Outpatient Services Other Practitioner Office Visit Emergency Care Emergency Care Emergency Care Laboratory and Imaging Laboratory and Imaging Maternity Care Maternity Care Hospital - Outpatient Hospital - Impatient Hospital - Impatient Well Baby Visits and Care Not Covered Not Covered Not Covered Not Covered Not Covered S20 Not Covered S60 S60* S60* Emergency Room Services 30% Coinsurance after deductible 30% Coinsurance after deductible 30% Coinsurance after deductible Not Covered	Preventive Care	Preventive Care/Screening/Immunization	<u> </u>	Not Covered
Office Visits Mental/Behavioral Health Outpatient Services Substance Abuse Disorder Outpatient Services Other Practitioner Office Visit Urgent Care Centers or Facilities Emergency Room Services Emergency Room Services Laboratory and Imaging Maternity Care Maternity Care Hospital - Outpatient Hospital - Inpatient Specialist Visit Mental/Behavioral Health Outpatient Services Substance Abuse Disorder Outpatient Substance After Substance After Adductible Substance After deductible Substance After deductible Substance After Adductible Substance After Addu		Well Baby Visits and Care	No Charge	Not Covered
Office Visits Mental/Behavioral Health Outpatient Services \$20		Primary Care Visit to Treat an Injury or Illness	\$20	Not Covered
Substance Abuse Disorder Outpatient Services Other Practitioner Office Visit Urgent Care Centers or Facilities Emergency Care Emergency Care Emergency Transportation/Ambulance Laboratory Outpatient and Professional Services Maternity Care Hospital - Outpatient Hospital - Inpatient Substance Abuse Disorder Outpatient Services Substance Abuse Disorder Outpatient Services \$20 Not Covered \$440 Not Covered \$60 \$60* \$60* \$60* \$30% Coinsurance after deductible 30% Coinsurance after deductible 30% Coinsurance after deductible 30% Coinsurance after deductible Not Covered		Specialist Visit	\$40	Not Covered
Other Practitioner Office Visit Emergency Care Emergency Care Emergency Care Emergency Care Emergency Room Services Emergency Transportation/Ambulance Laboratory and Imaging Laboratory Outpatient and Professional Services Imaging (CT/PET Scans, MRIs) Maternity Care Hospital - Outpatient All Other Maternity Care Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Hospital Services (e.g., Hospital Stay) Inpatient Hospital Services Other Practitioner Office Visit	Office Visits	Mental/Behavioral Health Outpatient Services	\$20	Not Covered
Emergency Care Emergency Room Services Emergency Transportation/Ambulance Laboratory and Imaging Maternity Care Hospital - Outpatient Hospital - Inpatient Urgent Care Centers or Facilities Emergency Room Services Emergency Room Services Emergency Transportation/Ambulance Laboratory Ambulance Laboratory Outpatient and Professional Services 30% Coinsurance after deductible Not Covered		Substance Abuse Disorder Outpatient Services	\$20	Not Covered
Emergency Care Emergency Room Services Emergency Transportation/Ambulance Laboratory Outpatient and Professional Services Laboratory and Imaging X-rays and Diagnostic Imaging Imaging (CT/PET Scans, MRIs) Maternity Care Hospital - Outpatient Hospital - Impatient Emergency Room Services Som Coinsurance after deductible 30% Coinsurance after deductible 30% Coinsurance after deductible Not Covered		Other Practitioner Office Visit	\$40	Not Covered
Emergency Transportation/Ambulance Laboratory and Imaging Laboratory and Diagnostic Imaging Maternity Care Hospital - Outpatient Laboratory Physician/Surgical Services Emergency Transportation/Ambulance Laboratory Outpatient and Professional Services 30% Coinsurance after deductible Not Covered	Emergency Care	Urgent Care Centers or Facilities	\$60	\$60*
Laboratory and Imaging Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging Maternity Care Hospital - Outpatient Laboratory Outpatient and Professional Services Laboratory Outpatient and Professional Services 30% Coinsurance after deductible Not Covered Impatient Hospital Services (e.g., Hospital Stay) Impatient Physician and Surgical Services 30% Coinsurance after deductible Not Covered		Emergency Room Services	30% Coinsurance after deductible	30% Coinsurance after deductible*
Laboratory and Imaging X-rays and Diagnostic Imaging Imaging (CT/PET Scans, MRIs) Maternity Care Prenatal Office Visits All Other Maternity Care Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Inpatient Hospital - Inpatient Hospital - Inpatient Waternity Care All Other Maternity Care Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Inpatient Hospital Services (e.g., Hospital Stay) Inpatient Physician and Surgical Services 30% Coinsurance after deductible Not Covered		Emergency Transportation/Ambulance	30% Coinsurance after deductible	30% Coinsurance after deductible*
Imaging (CT/PET Scans, MRIs) 30% Coinsurance after deductible Not Covered	Laboratory and Imaging	Laboratory Outpatient and Professional Services	30% Coinsurance after deductible	Not Covered
Maternity Care Prenatal Office Visits All Other Maternity Care Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Outpatient Hospital - Inpatient Hospital - Inpatien		X-rays and Diagnostic Imaging	30% Coinsurance after deductible	Not Covered
Maternity Care All Other Maternity Care Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Inpatient Hospital - Inpatient Hospital - Inpatient Mot Covered 30% Coinsurance after deductible Not Covered		Imaging (CT/PET Scans, MRIs)	30% Coinsurance after deductible	Not Covered
Hospital - Outpatient Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Inpatient Hospital - Inpatient Hospital - Inpatient Outpatient Surgery Physician and Surgical Services Outpatient Hospital Services (e.g., Hospital Stay) Inpatient Physician and Surgical Services Outpatient Hospital Services (e.g., Hospital Stay) Outpatient Hospital Services (e.g., Hospital Stay) Outpatient Hospital Services Outpatient Hospital Servic	Maternity Care	Prenatal Office Visits	No Charge	Not Covered
Hospital - Outpatient Outpatient Surgery Physician/Surgical Services 30% Coinsurance after deductible Not Covered Inpatient Hospital Services (e.g., Hospital Stay) 30% Coinsurance after deductible Not Covered Inpatient Physician and Surgical Services 30% Coinsurance after deductible Not Covered		All Other Maternity Care	30% Coinsurance after deductible	Not Covered
Outpatient Surgery Physician/Surgical Services 30% Coinsurance after deductible Not Covered Inpatient Hospital Services (e.g., Hospital Stay) 30% Coinsurance after deductible Not Covered Inpatient Physician and Surgical Services 30% Coinsurance after deductible Not Covered	Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% Coinsurance after deductible	Not Covered
Hospital - Inpatient Inpatient Physician and Surgical Services 30% Coinsurance after deductible Not Covered		Outpatient Surgery Physician/Surgical Services	30% Coinsurance after deductible	Not Covered
Hospital - Inpatient	Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	30% Coinsurance after deductible	Not Covered
Mental/Behavioral Health Inpatient Services 30% Coinsurance after deductible Not Covered		Inpatient Physician and Surgical Services	30% Coinsurance after deductible	Not Covered
,		Mental/Behavioral Health Inpatient Services	30% Coinsurance after deductible	Not Covered
Substance Abuse Disorder Inpatient Services 30% Coinsurance after deductible Not Covered		Substance Abuse Disorder Inpatient Services	30% Coinsurance after deductible	Not Covered
Reconstructive Surgery 30% Coinsurance after deductible Not Covered	Surgery	Reconstructive Surgery	30% Coinsurance after deductible	Not Covered
Bariatric Surgery 30% Coinsurance after deductible Not Covered		Bariatric Surgery	30% Coinsurance after deductible	Not Covered
			30% Coinsurance after deductible	Not Covered
Treatment for Temporomandibular Joint Disorders 30% Coinsurance after deductible Not Covered		Treatment for Temporomandibular Joint Disorders	30% Coinsurance after deductible	Not Covered
Accidental Dental 30% Coinsurance after deductible Not Covered		•	30% Coinsurance after deductible	Not Covered

Plan Year		2018	
Plan Name		Gold HRA 4500 Plan	
Market		Small Group	
Employer Contribution to HRA		\$500	
Category	Service	In Network	Out of Network
	Service	MHPC Directly Contracted	Out of Network
Home Health Care	Home Health Care Services	30% Coinsurance after deductible	Not Covered
	Hospice Services	30% Coinsurance after deductible	Not Covered
	Habilitation Services	30% Coinsurance after deductible	Not Covered
	Skilled Nursing Facility	30% Coinsurance after deductible	Not Covered
Autism Treatment	Outpatient Mental Health Services to Treat Autism	30% Coinsurance after deductible	Not Covered
	Habilitation Services to Treat Autism	30% Coinsurance after deductible	Not Covered
Other Services	Chiropractic Care	30% Coinsurance after deductible	Not Covered
	Diabetes Education	30% Coinsurance after deductible	Not Covered
	Allergy Testing	30% Coinsurance after deductible	Not Covered
	Routine Eye Exam (Adult)	30% Coinsurance after deductible	Not Covered
	Routine Eye Exam for Children	30% Coinsurance after deductible	Not Covered
	Eye Glasses for Children	30% Coinsurance after deductible	Not Covered
	Infertility Treatment	30% Coinsurance after deductible	Not Covered
	Weight Loss Programs	30% Coinsurance after deductible	Not Covered
	Chemotherapy	30% Coinsurance after deductible	Not Covered
	Dialysis	30% Coinsurance after deductible	Not Covered
	Durable Medical Equipment	30% Coinsurance after deductible	Not Covered
	Infusion Therapy	30% Coinsurance after deductible	Not Covered
	Outpatient Rehabilitation Services	30% Coinsurance after deductible	Not Covered
	Prosthetic Devices	30% Coinsurance after deductible	Not Covered
	Radiation	30% Coinsurance after deductible	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance after deductible	Not Covered
	Rehabilitative Speech Therapy	30% Coinsurance after deductible	Not Covered
	Prescription Drugs Other	30% Coinsurance after deductible	Not Covered
	Mental Health Other	30% Coinsurance after deductible	Not Covered
Prescription Drugs	Generic Drugs	\$10	Not Covered
	Preferred Brand Drugs	\$30	Not Covered
	Non-Preferred Brand Drugs	\$200	Not Covered
	Specialty Drugs	\$300	Not Covered

^{*} Balance billed amounts charged by the provider are the responsibility of the member

McLaren Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

Arabic:

. (رقم هاتف الصم والبكم: 711)ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671