2023

McLaren
MEDICARE

# SUMMARY OF BENEFITS

- McLaren Inspire (HMO)
  H6322-001
- McLaren Inspire Plus (HMO)
  H6322-002
- McLaren Inspire Flex (HMO-POS)
  H6322-003-01
- McLaren Inspire Flex (HMO-POS)
  H6322-003-02

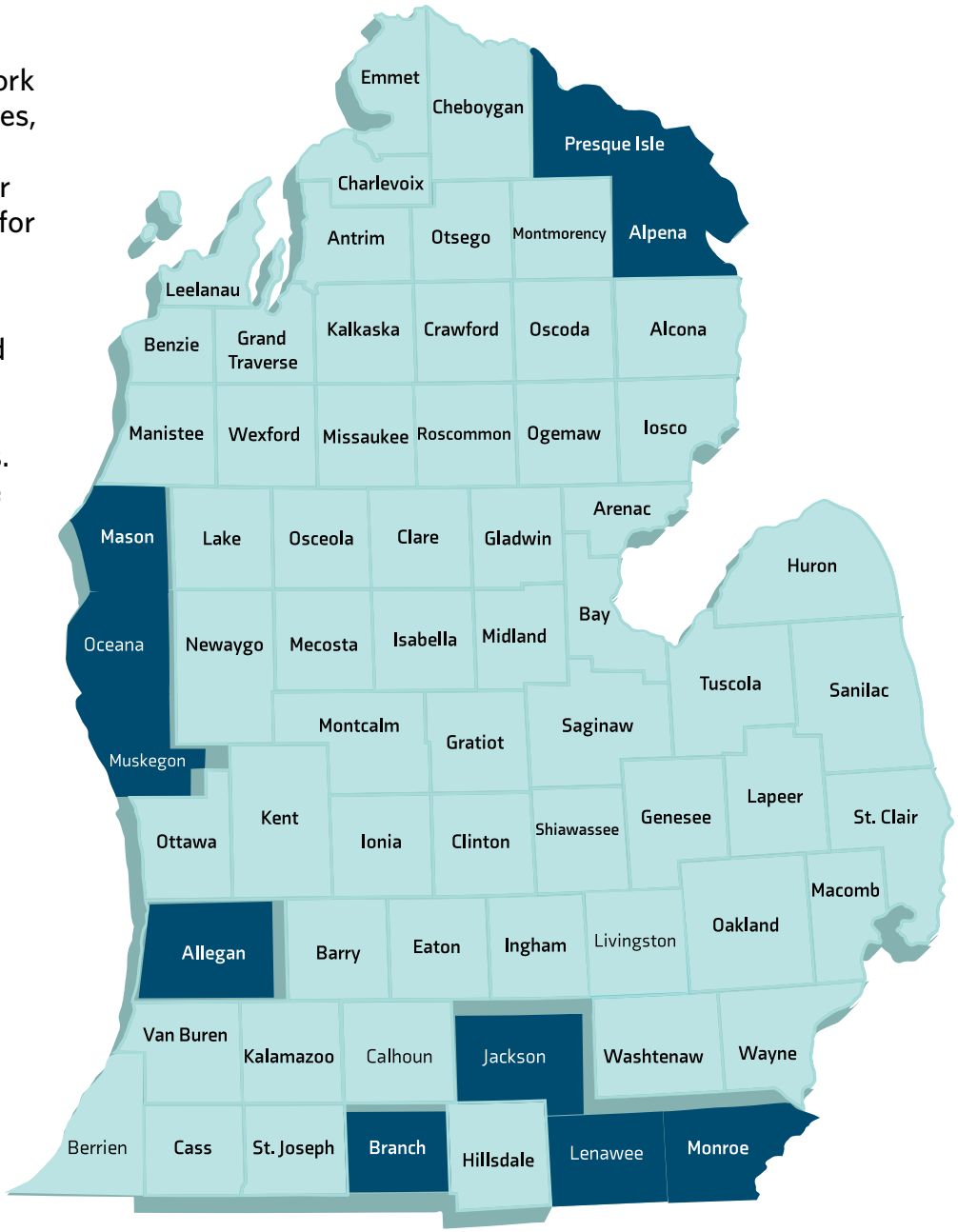
This is a summary of drug and health services covered by McLaren Medicare for January 1, 2023 - December 31, 2023

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To see a complete list of services we cover, please review the Evidence of Coverage on www.mclarenhealthplan.org/medicare.

To join **McLaren Medicare** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Michigan: Alcona, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Calhoun, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Livingston, Macomb, Manistee, Mecosta, Midland, Missaukee, Montcalm, Montmorency, Newaygo, Oakland, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, St. Clair, St. Joseph, Sanilac, Shiawassee, Tuscola, Van Buren, Washtenaw, Wayne, and Wexford.

**McLaren Medicare** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

Out-of-network/noncontracted providers are under no obligation to treat members, except in emergency situations. Please call our member service number or review the Evidence of Coverage for more information, including the cost sharing that applies to out-of network services.




**KEY**

- Approved areas
- Non-approved areas

# Monthly Premium, Deductibles, and Coverage Limits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01* | McLaren Inspire Flex (HMO-POS) H6322-003-02** |
|---|---|---|---|---|
| **Your Monthly Plan Premium** (in addition to your Medicare Part B premium) | $0 | $25 | $0 | $49 |
| **Deductible** | **Medical services** $0 **Prescription drug** All Tiers $0 | **Medical services** $0 **Prescription drug** All Tiers $0 | **Medical services** $0 **Prescription drug** All Tiers $0 | **Medical services** $0 **Prescription drug** All Tiers $0 |
| **Maximum Out-of-Pocket Responsibility** This is the most you will pay for copays, coinsurance, and other costs for medical services for the calendar year. | $4,200 for in-network Medicare-covered benefits | $3,500 for in-network Medicare-covered benefits | $3,800 for in-network Medicare-covered benefits | $3,800 for in-network Medicare-covered benefits |

*This plan is only available to people who reside in Bay, Charlevoix, Cheboygan, Clinton, Emmet, Genesee, Ingham, Isabella, Lapeer, Macomb, Oakland, and St. Clair counties.

**This plan is only available to people who reside in Alcona, Antrim, Arenac, Barry, Benzie, Berrien, Calhoun, Cass, Clare, Crawford, Eaton, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ionia, Iosco, Isabella, Kalamazoo, Kalkaska, Kent, Lake, Leelanau, Livingston, Manistee, Mecosta, Midland, Missaukee, Montcalm, Montmorency, Newaygo, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, St. Joseph, Sanilac, Shiawassee, Tuscola, Van Buren, Washtenaw, Wayne, and Wexford counties.

# Covered Medical Benefits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Inpatient Hospital Coverage**<br>We cover an unlimited number of days for an inpatient hospital stay.<br>Prior authorization may be required. | $275 copay per day for days 1 through 7<br>You pay nothing per day for days 8 - 90<br>You pay nothing per day for days 91 and beyond | $225 copay per day for days 1 through 7<br>You pay nothing per day for days 8 - 90<br>You pay nothing per day for days 91 and beyond | **In-network**<br>$200 copay per day for days 1 through 7<br>You pay nothing per day for days 8 - 90<br>You pay nothing per day for days 91 and beyond<br>**Point-of-service**<br>20% of the cost/stay | **In-network**<br>$200 copay per day for days 1 through 7<br>You pay nothing per day for days 8 - 90<br>You pay nothing per day for days 91 and beyond<br>**Point-of-service**<br>30% of the cost/stay |
| **Outpatient Hospital Coverage**<br>Prior authorization may be required. | **Outpatient hospital:**<br>$200 copay for per visit<br>**Ambulatory surgical center:**<br>$200 copay for per visit<br>**Observation:**<br>$150 copay for each visit | **Outpatient hospital:**<br>$200 copay for per visit<br>**Ambulatory surgical center:**<br>$150 copay for per visit<br>**Observation:**<br>$150 copay for per visit | **In-network**<br>**Outpatient hospital:**<br>$150 copay for per visit<br>**Ambulatory surgical center:**<br>$150 copay for per visit<br>**Observation:**<br>$150 copay for per visit<br>**Point-of-service**<br>20% of the cost | **In-network**<br>**Outpatient hospital:**<br>$200 copay for per visit<br>**Ambulatory surgical center:**<br>$150 copay for per visit<br>**Observation:**<br>$150 copay for per visit<br>**Point-of-service**<br>30% of the cost |
| **Doctor Visits**<br>No referral required for an in-network specialist visits. | **Primary care:**<br>$0 copay per visit<br>**Specialist:**<br>$40 copay per visit | **Primary care:**<br>$0 copay per visit<br>**Specialist:**<br>$25 copay per visit | **In-network**<br>**Primary care:**<br>$0 copay per visit<br>**Specialist:**<br>$30 copay per visit<br>**Point-of-service**<br>20% of the cost | **In-network**<br>**Primary care:**<br>$0 copay per visit<br>**Specialist:**<br>$30 copay per visit<br>**Point-of-service**<br>30% of the cost |
| **Preventive Care** | $0 copay | $0 copay | **In-network:**<br>$0 copay<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>$0 copay<br>**Point-of-service**<br>30% of the cost |

# Covered Medical Benefits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Emergency Care**<br>Your copay will be waived if you are admitted directly into the hospital. | You pay a $95 copay per visit in or out of network | You pay a $95 copay per visit in or out of network | You pay a $95 copay per visit in or out of network | You pay a $95 copay per visit in or out of network |
| **Urgently Needed Services** | You pay a $50 copay per visit in or out of network | You pay a $50 copay per visit in or out of network | You pay a $50 copay per visit in or out of network | You pay a $50 copay per visit in or out of network |
| **Outpatient Diagnostic Services/Labs/ Imaging**<br>Prior authorization required for genetic testing. | **Diagnostic radiology service (CT/MRI):** $200 copay<br>**Lab services:** $0 copay<br>**Diagnostic tests and procedures:** $20 copay<br>**Outpatient X-rays:** $25 copay | **Diagnostic radiology service (CT/MRI):** $150 copay<br>**Lab services:** $0 copay<br>**Diagnostic tests and procedures:** $20 copay<br>**Outpatient X-rays:** $25 copay | **In-network Diagnostic radiology service (CT/MRI):** $100 copay<br>**Lab services:** $0 copay<br>**Diagnostic tests and procedures:** $10 copay<br>**Outpatient X-rays:** $35 copay<br>**Point-of-service** 20% of the cost | **In-network Diagnostic radiology service (CT/MRI):** $125 copay<br>**Lab services:** $0 copay<br>**Diagnostic tests and procedures:** $20 copay<br>**Outpatient X-rays:** $25 copay<br>**Point-of-service** 30% of the cost |

# Covered Medical Benefits

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|---|---|---|---|---|
| **Hearing Services**<br>Must use TruHearing providers for all routine hearing exams and hearing aid services. | **Hearing exams:**<br>You pay a $40 copay for a Medicare-covered hearing exam<br>You pay a $0 copay for non-Medicare covered routine hearing exams<br>**Hearing aids:**<br>You pay a $0 for one hearing aid fitting and evaluation per year.<br>$699/$999 copay per hearing aid – one per ear every 2 years | **Hearing exams:**<br>You pay a $25 copay for a Medicare-covered hearing exam<br>You pay a $0 copay for non-Medicare covered routine hearing exams<br>**Hearing aids:**<br>You pay a $0 for one hearing aid fitting and evaluation per year.<br>$699/$999 copay per hearing aid – one per ear every 2 years | **In-network Hearing exams:**<br>You pay a $30 copay for a Medicare-covered hearing exam<br>You pay a $0 copay for non-Medicare covered routine hearing exams<br>**Point-of-service**<br>20% of the cost<br>**Hearing aids:**<br>You pay a $0 for one hearing aid fitting and evaluation per year.<br>$699/$999 copay per hearing aid – one per ear every 2 years | **In-network Hearing exams:**<br>You pay a $30 copay for a Medicare-covered hearing exam<br>You pay a $0 copay for non-Medicare covered routine hearing exams<br>**Point-of-service**<br>30% of the cost<br>**Hearing aids:**<br>You pay a $0 for one hearing aid fitting and evaluation per year.<br>$699/$999 copay per hearing aid – one per ear every 2 years |
| **Dental Services**<br>In-network preventive dental services are provided by Delta Dental's Medicare Advantage PPO and Premier network dentists. | **Oral exam and cleaning:** $0 copay for two exams and two cleanings (regular or periodontal) each year<br>**Filling and crown repair:** 50% coinsurance<br>**Fluoride treatment:** $0 copay for one treatment each year<br>**Bitewing X-rays:** $0 copay for one set each year<br>**Full mouth X-rays:** $0 copay once every 5 years<br>**Simple extractions:** 50% coinsurance<br>**$1,500 maximum benefit for dental services.** | | | |

# Optional Supplemental Dental
(can be purchased separately)

| | Delta Dental Option 1 | Delta Dental Option 2 |
|---|---|---|
| **Premium**<br>These optional dental plans can be purchased for an additional monthly premium. For Delta Dental Option 1 and Delta Dental Option 2, services must be provided by Delta Dental's Medicare Advantage PPO or Premier network dentists. | $24.50 | $38 |
| **Deductible** | $0 | $0 |
| **Services** | **Major restorative services, bridges, dentures, and implant services:**<br>75% coinsurance<br>**Endodontics, periodontics (surgical), bridge and denture repair, oral surgery, and films, anesthesia and tests:**<br>50% coinsurance | **Major restorative services, bridges, dentures, and implant services:**<br>50% coinsurance<br>**Endodontics, periodontics (surgical), bridge and denture repair, oral surgery, and films, anesthesia and tests:**<br>20% coinsurance |
| **Maximum Benefit Limit** | You will be covered for $1,000 of dental services per year. Once you reach this limit, you will have to pay all costs for dental services. | You will be covered for $1,500 of dental services per year. Once you reach this limit, you will have to pay all costs for dental services. |

# Covered Medical Benefits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Vision Services** | **Medicare-covered services:**<br>$40 copay for per visit<br>$0 copay for eyeglasses or contact lenses after cataract surgery<br>$0 copay for glaucoma screening<br><br>**Routine vision services:**<br>$0 copay for a routine eye exam<br>$0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses up to $100. | **Medicare-covered services:**<br>$25 copay for per visit<br>$0 copay for eyeglasses or contact lenses after cataract surgery<br>$0 copay for glaucoma screening<br><br>**Routine vision services:**<br>$0 copay for a routine eye exam<br>$0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses up to $200. | **In-network Medicare-covered services:**<br>$30 copay for per visit<br>$0 copay for eyeglasses or contact lenses after cataract surgery<br>$0 copay for glaucoma screening<br><br>**Routine vision services:**<br>$0 copay for a routine eye exam<br>$0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses up to $200.<br><br>**Point-of-service**<br>20% of the cost | **In-network Medicare-covered services:**<br>$25 copay for per visit<br>$0 copay for eyeglasses or contact lenses after cataract surgery<br>$0 copay for glaucoma screening<br><br>**Routine vision services:**<br>$30 copay for a routine eye exam<br>$0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses up to $200.<br><br>**Point-of-service**<br>30% of the cost |
| **Mental Health Services**<br>Our plan covers up to 190 days in a lifetime for inpatient care in a psychiatric hospital. Our plan covers 90 days for an inpatient hospital stay.<br>Prior authorization may be required for inpatient mental health services. | **Inpatient:**<br>$275 copay per day for days 1 through 7<br>You pay nothing for days 8 through 90<br><br>**Outpatient therapy (group or individual):**<br>$30 copay per session | **Inpatient:**<br>$225 copay per day for days 1 through 7<br>You pay nothing for days 8 through 90<br><br>**Outpatient therapy (group or individual):**<br>$25 copay per session | **In-network Inpatient:**<br>$200 copay per day for days 1 through 7<br>You pay nothing for days 8 through 90<br><br>**Outpatient therapy (group or individual):**<br>$30 copay per session<br><br>**Point-of-service**<br>20% of the cost | **In-network Inpatient:**<br>$200 copay per day for days 1 through 7<br>You pay nothing for days 8 through 90<br><br>**Outpatient therapy (group or individual):**<br>$25 copay per session<br><br>**Point-of-service**<br>30% of the cost |

# Covered Medical Benefits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Skilled Nursing Facility (SNF)**<br>Our plan covers up to 100 days each benefit period in a SNF. A benefit period starts the day you go into a SNF and ends when you go 60 days in a row without SNF care.<br>Prior authorization may be required. | You pay nothing per day for days 1 through 20<br>$196 copay per day for days 21 through 100 | You pay nothing per day for days 1 through 20<br>$196 copay per day for days 21 through 100 | **In-network:**<br>You pay nothing per day for days 1 through 20<br>$196 copay per day for days 21 through 100<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>You pay nothing per day for days 1 through 20<br>$196 copay per day for days 21 through 100<br>**Point-of-service**<br>30% of the cost |
| **Physical Therapy**<br>Prior authorization may be required. | $25 copay per visit | $25 copay per visit | **In-network:**<br>$30 copay per visit<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>$25 copay per visit<br>**Point-of-service**<br>30% of the cost |
| **Ambulance (Air/Ground)**<br>Prior authorization is required for Medicare-covered non-emergency transport. | $220 copay per one-way transport | $220 copay per one-way transport | $200 copay per one-way transport | $220 copay per one-way transport |
| **Transportation** | You pay nothing for up to 20 one-way non-emergency trips per year to plan approved health-related locations | You pay nothing for up to 20 one-way non-emergency trips per year to plan approved health-related locations | You pay nothing for up to 20 one-way non-emergency trips per year to plan approved health-related locations | You pay nothing for up to 20 one-way non-emergency trips per year to plan approved health-related locations |
| **Medicare Part B Drugs**<br>Prior authorization may be required. | **Chemotherapy and other Part B drugs:**<br>20% of the cost<br>**Home infusion drugs:**<br>$0 copay | **Chemotherapy and other Part B drugs:**<br>20% of the cost<br>**Home infusion drugs:**<br>$0 copay | **In-network: Chemotherapy and other Part B drugs:**<br>20% of the cost<br>**Home infusion drugs:**<br>$0 copay<br>**Point-of-service**<br>20% of the cost | **In-network: Chemotherapy and other Part B drugs:**<br>20% of the cost<br>**Home infusion drugs:**<br>$0 copay<br>**Point-of-service**<br>30% of the cost |

# Prescription Drug Benefits

| | McLaren Inspire (HMO) H6322-001 | | McLaren Inspire Plus (HMO) H6322-002 | | McLaren Inspire Flex (HMO-POS) H6322-003-01 | | McLaren Inspire Flex (HMO-POS) H6322-003-02 | |
|---|---|---|---|---|---|---|---|---|
| **Stage 1: Deductible** | Because you have no deductible, you will start in the Initial Coverage Stage when you fill your first prescription of the year. | | | | | | | |
| **Stage 2: Initial Coverage Stage** You will pay the copays/coinsurance until your total drug cost reaches $4,660. | **Retail pharmacy** (30-day Supply) | **Mail-order pharmacy** (90-day Supply) | **Retail pharmacy** (30-day Supply) | **Mail-order pharmacy** (90-day Supply) | **Retail pharmacy** (30-day Supply) | **Mail-order pharmacy** (90-day Supply) | | |
| **Tier 1: Preferred Generic** | $0 | $0 | $0 | $0 | $0 | $0 | | |
| **Tier 2: Generic** | $12 Select Insulins: $10 | $27 Select Insulins: $23 | $12 Select Insulins: $10 | $27 Select Insulins: $23 | $12 Select Insulins: $10 | $27 Select Insulins: $23 | | |
| **Tier 3: Preferred Brand** | $47 Select Insulins: $35 | $105.75 Select Insulins: $79 | $47 Select Insulins: $35 | $105.75 Select Insulins: $79 | $47 Select Insulins: $35 | $105.75 Select Insulins: $79 | | |
| **Tier 4: Non-Preferred Brand** | $100 | $225 | $100 | $225 | $100 | $225 | | |
| **Tier 5: Specialty** | 33% | Not Available | 33% | Not Available | 33% | Not Available | | |
| **Tier 6: Select Care Drugs** | $0 | $0 | $0 | $0 | $0 | $0 | | |

# Prescription Drug Benefits

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Stage 3: Coverage Gap Stage** | During this stage, you will continue to have plan coverage for your drugs in Tier 1 and Tier 6. Your out-of-pocket costs for Select Insulins will be $10-$35. For all other generic drugs, you will pay 25% of the price. For brand-name drugs you pay 25% of the price (plus a portion of the dispensing fee). You will remain in this stage until your out-of-pocket costs reach $7,400. | | | |
| **Stage 4: Catastrophic Coverage Stage** | In this stage, your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:<br>either – coinsurance of 5% of the cost of the drug<br>or $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.<br>Our plan pays the rest of the cost. | | | |

# Additional Covered Medical Coverage

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Acupuncture**<br>Medicare-covered acupuncture for chronic lower back pain. | $25 copay per visit | $25 copay per visit | **In-network:**<br>$30 copay per visit<br>**Point-of-service**<br>Not covered out-of-network | **In-network:**<br>$25 copay per visit<br>**Point-of-service**<br>Not covered out-of-network |
| **Annual Physical Exam**<br>Comprehensive preventive medical evaluation. | $0 copay per visit | $0 copay per visit | **In-network:**<br>$0 copay per visit<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>$0 copay per visit<br>**Point-of-service**<br>30% of the cost |
| **Chiropractic Care** | $20 copay per visit | $20 copay per visit | **In-network:**<br>$20 copay per visit<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>$20 copay per visit<br>**Point-of-service**<br>30% of the cost |
| **Durable Medical Equipment**<br>Prior authorization is required for items that cost more than $1000, insulin pumps, and bone stimulators. | You pay a 20% coinsurance | You pay a 20% coinsurance | **In-network:**<br>You pay a 20% coinsurance<br>**Point-of-service**<br>20% of the cost | **In-network:**<br>You pay a 20% coinsurance<br>**Point-of-service**<br>30% of the cost |
| **Enhanced Disease Management** | If you have a chronic conditions you may qualify for one of our enhanced disease management programs. These special educational programs promote a deep understanding of the disease process and provide individual teaching and coaching to help you have a healthier lifestyle. A care manager is available to those who qualify for these customized programs.<br>You pay nothing for enhanced disease management | | | |
| **Fitness Membership** | Our plan will reimburse you for up to a maximum of $100 annually for your fitness center membership. | Our plan will reimburse you for up to a maximum of $200 annually for your fitness center membership. | Our plan will reimburse you for up to a maximum of $200 annually for your fitness center membership. | Our plan will reimburse you for up to a maximum of $200 annually for your fitness center membership. |
| **Meals After Discharge** | $0 for 2 meals per day for 14 days (28 meals), delivered directly to your home after each discharge from an inpatient acute care or skilled nursing facility stay. Annual limit of 5 discharges for a total of 140 meals per year. | | | |

# Additional Covered Medical Coverage

| | McLaren Inspire (HMO) H6322-001 | McLaren Inspire Plus (HMO) H6322-002 | McLaren Inspire Flex (HMO-POS) H6322-003-01 | McLaren Inspire Flex (HMO-POS) H6322-003-02 |
|---|---|---|---|---|
| **Nutritional/ Dietary Benefit** | We cover 6 counseling sessions through a registered dietitian or other nutrition professional. We want to help you improve your health and lifestyle by providing tools so you make healthy choices. Talk to your physician to see if you would benefit from nutritional counseling.<br>You pay nothing for these sessions. | | | |
| **Over-the-Counter Items** | You are eligible for a $60 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products that do not need a prescription. No rollover. | | | |
| **Prosthetic Devices and Related Medical Supplies**<br>Prior authorization is required for items that cost more than $1,000. | You pay a 20% coinsurance | You pay a 20% coinsurance | **In-network**<br>You pay a 20% coinsurance<br>**Point-of-service**<br>20% of the cost | **In-network**<br>You pay a 20% coinsurance<br>**Point-of-service**<br>30% of the cost |
| **Worldwide Emergency** | Not Covered | You may receive covered emergency and urgent care services anywhere in the world. If you are outside of the United States or its territories, your worldwide emergency and urgent care is limited to $50,000 per year. All costs over $50,000 for emergency and urgent care services are your responsibility.<br>You pay a $95 copay per visit. | | |
| **Worldwide Urgent Care** | Not Covered | You may receive covered emergency and urgent care services anywhere in the world. If you are outside of the United States or its territories, your worldwide emergency and urgent care is limited to $50,000 per year. All costs over $50,000 for emergency and urgent care services are your responsibility.<br>You pay a $50 copay per visit. | | |

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
This document is available in other formats such as Braille, large print, or audio.

For more information, please call us at the phone number below or visit us at **www.mclarenhealthplan.org/medicare.**

Toll-free 1-833-358-2404, TTY users should call 711.
From October 1st to March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern Time.(except Thanksgiving and Christmas days)
From April 1st to September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time.
You can see our plan's provider/pharmacy directory at our website at **www.mclarenhealthplan.org/medicare.**

**McLaren Medicare** is an HMO/HMO-POS plan with a Medicare contract. Enrollment in McLaren Medicare depends on contract renewal.

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