2022

McLaren MEDICARE

SUMMARY OF BENEFITS

McLaren Medicare Inspire (HMO) H6322, Plan 001
McLaren Medicare Inspire Plus (HMO) H6322, Plan 002
McLaren Medicare Inspire Flex (HMO-POS) H6322, Plan 003

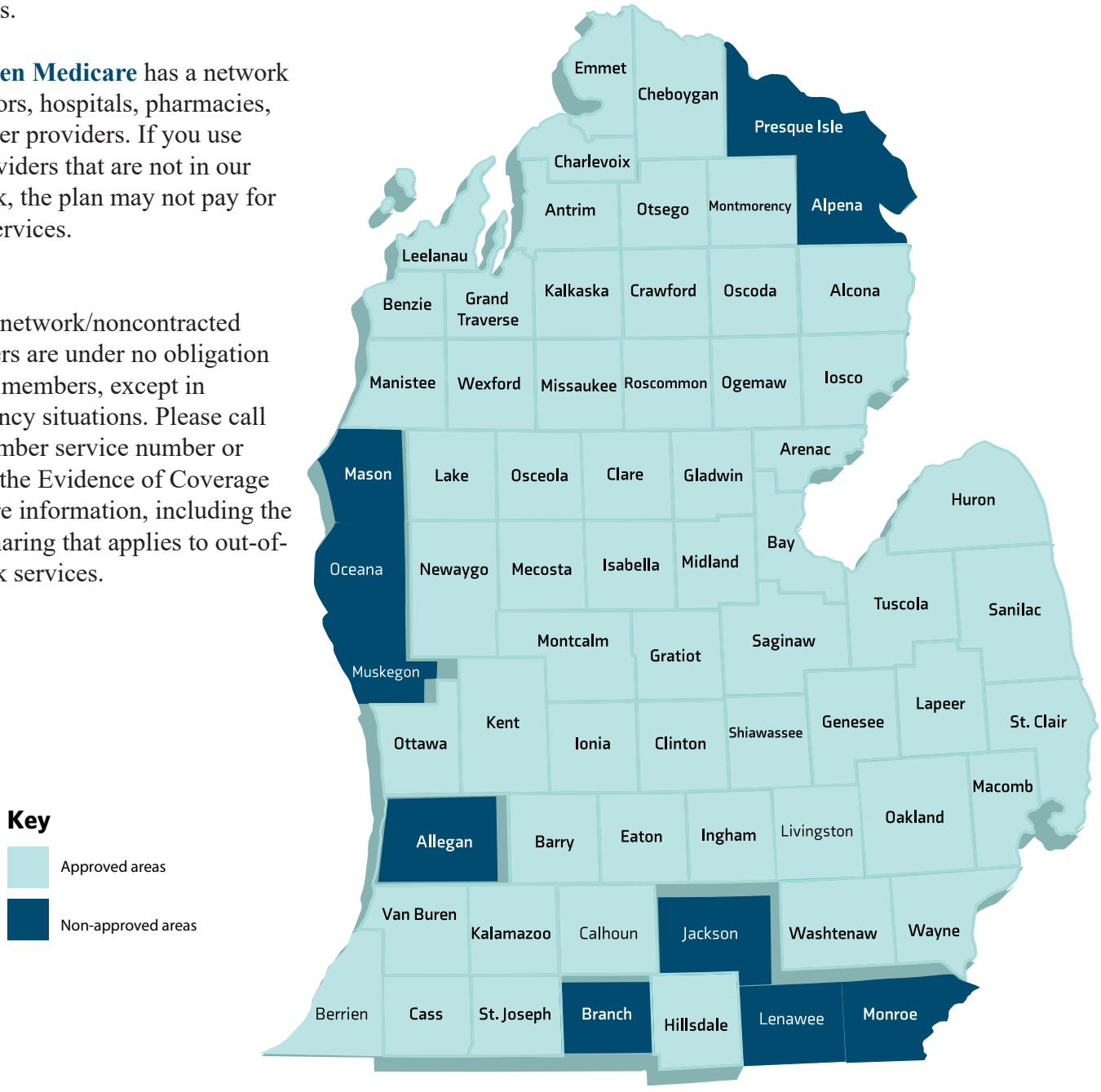
This is a summary of drug and health services covered by McLaren Medicare for January 1, 2022 - December 31, 2022

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 counties.

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.



Monthly Premium, Deductibles, and Coverage Limits

	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Your Monthly Plan Premium (in addition to your Medicare Part B premium)	You pay $0	You pay $25	You pay $49
Deductible	**Medical Services** $300 **Prescription Drug** Tiers 3 – 5: $100	**Medical Services** $0 **Prescription Drug** $0	**Medical Services** $100 in-network only **Prescription Drug** $0
Maximum Out-of-Pocket Responsibility This is the most you will pay for copays, coinsurance, and other costs for medical services for the year.	$5,200 for in-network Medicare-covered benefits	$3,800 for in-network Medicare-covered benefits	$3,800 for in-network Medicare-covered benefits

Covered Medical Benefits

Medical Benefits	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Inpatient Hospital Coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	$250 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond	$200 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond	**In-network** $200 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 You pay nothing per day for days 91 and beyond **Point-of-service** 30% of the cost/stay
Outpatient Hospital Coverage Prior authorization and referral may be required.	**Outpatient Hospital:** $200 copay for each visit **Ambulatory Surgical Center:** $200 copay for each visit **Observation:** $150 copay for each visit	**Outpatient Hospital:** $200 copay for each visit **Ambulatory Surgical Center:** $150 copay for each visit **Observation:** $150 copay for each visit	**In-network** **Outpatient Hospital:** $200 copay for each visit **Ambulatory Surgical Center:** $150 copay for each visit **Observation:** $150 copay for each visit **Point-of-service** 30% of the cost
Doctor Visits Specialist visits require a referral.	**Primary Care:** $5 copay per visit **Specialist:** You pay a $40 copay per visit	**Primary Care:** $0 copay per visit **Specialist**: You pay a $25 copay per visit	**In-network** **Primary Care**: $0 copay per visit **Specialist:** You pay a $25 copay per visit **Point-of-service** 30% of the cost

Covered Medical Benefits

Medical Benefits	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Preventive Care	You pay nothing	You pay nothing	**In-network** You pay nothing **Point-of-service** 30% of the cost
Emergency Care Your copay will be waived if you are admitted directly into the hospital.	You pay a $90 copay per visit in or out of network	You pay a $90 copay per visit in or out of network	You pay a $90 copay per visit in or out of network
Urgently Needed Services	You pay a $40 copay per visit in or out of network	You pay a $40 copay per visit in or out of network	You pay a $40 copay per visit in or out of network
Outpatient Diagnostic Services/Labs/ Imaging Prior authorization and referral may be required. Outpatient X-rays do not require prior authorization or referral.	**Diagnostic radiology service (CT/MRI):** $200 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $20 copay **Outpatient X-rays:** $25 copay	**Diagnostic radiology service (CT/MRI):** $150 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $20 copay **Outpatient X-rays:** $25 copay	**In-network** **Diagnostic radiology service (CT/MRI):** $150 copay **Lab services:** $0 copay **Diagnostic tests and procedures:** $20 copay **Outpatient X-rays:** $25 copay **Point-of-service** 30% of the cost

Covered Medical Benefits

Medical Benefits	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Hearing Services	**Hearing exams:** You pay a $40 copay for a Medicare-covered hearing exam You pay a $10 copay for non-Medicare covered routine hearing exams **Hearing aids:** You pay a $10 for one hearing aid fitting and evaluation per year. You will be reimbursed for up to $750 per year for hearing aids.	**Hearing exams:** You pay a $30 copay for a Medicare-covered hearing exam You pay a $0 copay for non-Medicare covered routine hearing exams **Hearing aids:** You pay a $0 for one hearing aid fitting and evaluation per year. You will be reimbursed for up to $1500 per year for hearing aids.	**In-network** **Hearing exams:** You pay a $30 copay for a Medicare-covered hearing exam You pay a $0 copay for non-Medicare covered routine hearing exams **Point-of-service** 30% of the cost **Hearing aids:** You pay a $0 for one hearing aid fitting and evaluation per year. You will be reimbursed for up to $1500 per year for hearing aids.
Dental Services 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 each year **Filings and crown repair:** 50% coinsurance **Fluoride treatment:** $0 copay for one treatment each year **Bitewing X-rays:** $0 copay for one set each year **Full mouth X-rays:** $0 copay once every 5 years		

Covered Medical Benefits			
Medical Benefits	**McLaren Medicare Inspire (HMO)**	**McLaren Medicare Inspire Plus (HMO)**	**McLaren Medicare Inspire Flex (HMO-POS)**
Vision Services	**Medicare-covered services:** $40 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses. You will be reimbursed up to a maximum of $100 each year.	**Medicare-covered services:** $30 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses. You will be reimbursed up to a maximum of $200 each year.	**In-network Medicare-covered services:** $30 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for glaucoma screening **Point-of-service** 30% of the cost **Routine vision services:** $0 copay for a routine eye exam $0 copay for non-Medicare-covered routine corrective eyeglasses (lenses and frames) or contact lenses. You will be reimbursed up to a maximum of $200 each year.
Mental Health Services 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. Prior authorization may be required for inpatient mental health services.	**Inpatient:** $250 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $30 copay per session	**Inpatient:** $200 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $25 copay per session	**In-network Inpatient:** $200 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 **Outpatient therapy (group or individual):** $25 copay per session **Point-of-service** 30% of the cost

Covered Medical Benefits			
Medical Benefits	**McLaren Medicare Inspire (HMO)**	**McLaren Medicare Inspire Plus (HMO)**	**McLaren Medicare Inspire Flex (HMO-POS)**
Skilled Nursing Facility (SNF) 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. Prior authorization may be required.	You pay nothing per day for days 1 through 20 $188 copay per day for days 21 through 100	You pay nothing per day for days 1 through 20 $188 copay per day for days 21 through 100	**In-network** You pay nothing per day for days 1 through 20 $188 copay per day for days 21 through 100 **Point-of-service** 30% of the cost
Physical Therapy Prior authorization and referral may be required.	$25 copay per visit	$25 copay per visit	**In-network** $25 copay per visit **Point-of-service** 30% of the cost
Ambulance Prior authorization may be required for Medicare covered non-emergency transport.	$250 copay per one-way transport	$250 copay per one-way transport	$250 copay per one-way transport in or out of network
Transportation Prior authorization and referral may be required.	Not covered	You pay nothing for up to 20 one-way non-emergency trips per year to plan approved health-related locations	Not covered
Medicare Part B Drugs Prior authorization may be required	**Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay	**Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay	**In-network** **Chemotherapy and Other Part B Drugs:** 20% of the cost **Home Infusion Drugs:** $0 copay **Point-of-service** 30% of the cost

Prescription Drug Benefits

Stage	McLaren Medicare Inspire (HMO)		McLaren Medicare Inspire Plus (HMO)		McLaren Medicare Inspire Flex (HMO-POS)	
Stage 1: Deductible Stage For plans with a deductible, you start here when you fill your first prescription of the year.	You pay the full cost for drugs in tiers 3-5 until your out-of-pocket costs reach $100. Once you pay $100 for drugs in tiers 3 – 5 you will move to the Initial Coverage Stage During this stage, your out-of-pocket costs for a 30-day supply of Select Insulins will be $10-$35.		$0 Because you have no deductible, you will start in the Initial Coverage Stage when you fill your first prescription of the year.		$0 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 Once you have paid your deductible, if applicable, you will pay the following copays/ coinsurance until your total drug cost (what you pay plus what we pay) reaches $4,430.	**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	$3.50	$7.88	$3.50	$7.88	$3.50	$7.88
Tier 2: Generic	$12.50 Select Insulins: $10	$28.13 Select Insulins: $22	$12.50 Select Insulins: $10	$28.13 Select Insulins: $22	$12.50 Select Insulins: $10	$28.13 Select Insulins: $22
Tier 3: Preferred Brand	$47 Select Insulins: $35	$105.75 Select Insulins: $78	$47 Select Insulins: $35	$105.75 Select Insulins: $78	$47 Select Insulins: $35	$105.75 Select Insulins: $78
Tier 4: Non-Preferred Brand	$100	$225	$100	$225	$100	$225
Tier 5: Specialty Tier	31%	N/A	33%	N/A	33%	N/A
Tier 6: Select Care Drugs	$0	N/A	$0	N/A	$0	N/A

Prescription Drug Benefits

Stage	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Stage 3: Coverage Gap Stage	During this stage, you continue to pay your copay for drugs on Tier 1. Your out-of-pocket costs for Select Insulins will be $10-$35. For all other generics, you 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 $7,050.		
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: o – either – coinsurance of 5% of the cost of the drug o –or – $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs. Our plan pays the rest of the cost.		

Optional Supplemental Dental Benefits

	Delta Dental Option 1	Delta Dental Option 2
Premium Optional dental premium must be paid in addition to your Medicare Part B and monthly premiums.	$24 per month	$36 per month
Deductible	$0	$0
Services	**Major restorative services, bridges, dentures, and implant services:** 75% coinsurance **Endodontics, periodontics, bridge and denture repair, simple extractions, oral surgery, and films, anesthesia & tests:** 50% coinsurance	**Major restorative services, bridges, dentures, and implant services:** 50% coinsurance **Endodontics, periodontics, bridge and denture repair, simple extractions, oral surgery, and films, anesthesia & tests**: 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.

Additional Covered Medical Benefits

Medical Benefits	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Acupuncture Medicare-covered acupuncture for chronic lower back pain	You pay a $25 copay per visit	You pay a $25 copay per visit	**In-network** You pay a $25 copay per visit **Point-of-service** Not covered out-of-network
Annual Physical Exam Comprehensive preventive medical evaluation	You pay nothing	You pay nothing	**In-network** You pay nothing **Point-of-service** 30% of the cost
Chiropractic care	You pay a $20 copay per visit	You pay a $20 copay per visit	**In-network** You pay a $20 copay per visit **Point-of-service** 30% of the cost
Durable medical equipment Prior authorization may be required	You pay a 20% coinsurance	You pay a 20% coinsurance	**In-network** You pay a 20% coinsurance **Point-of-service** 30% of the cost
Enhanced disease management Prior authorization and referral may be required	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. You pay nothing for enhanced disease management		
Fitness membership	Our plan will reimburse you for up to a maximum of $100 for your fitness center membership	Our plan will reimburse you for up to a maximum of $200 for your fitness center membership	Our plan will reimburse you for up to a maximum of $200 for your fitness center membership

Additional Covered Medical Benefits

Medical Benefits	McLaren Medicare Inspire (HMO)	McLaren Medicare Inspire Plus (HMO)	McLaren Medicare Inspire Flex (HMO-POS)
Meals after discharge Prior authorization and referral may be required	Not covered	Benefit covers 28 meals (2 meals per day for 14 days) delivered directly to your home after each discharge from an inpatient acute or a skilled nursing facility stay. Annual limit of 5 discharges for a total of 140 meals per year.	Benefit covers 28 meals (2 meals per day for 14 days) delivered directly to your home after each discharge from an inpatient acute or a skilled nursing facility stay. Annual limit of 5 discharges for a total of 140 meals per year.
Nutritional/dietary benefit Prior authorization may be required	We cover 6 counseling sessions through a registered dietician 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 nutrition counseling. You pay nothing for these sessions		
Over-the-counter items	You are eligible for a $50 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products that do not need a prescription.		
Prosthetic devices and related medical supplies	You pay a 20% coinsurance	You pay a 20% coinsurance	**In-network** You pay a 20% coinsurance **Point-of-service** 30% of the cost
Worldwide emergency 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 coverage is limited to $50,000 per year. All costs over $50,000 for worldwide emergency and urgent care services are your responsibility. You pay a $90 copay per visit.	
Worldwide urgently needed services	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 coverage is limited to $50,000 per year. All costs over $50,000 for worldwide emergency and urgent care services are your responsibility. You pay a $40 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.
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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