McLaren HEALTH PLAN

| Plan Year | | 2022 | |
|---|---|---|---|
| Plan Name | | McLaren Silver Exchange Plan - Virtual Care Plan | |
| Market | | Individual - On/Off Exchange | |
| **Category** | **Service** | **In Network** | **Out of Network** |
| General Plan Information | Individual Deductible | $3,700 | Not Applicable |
| | Family Deductible | $7,400 | Not Applicable |
| | Member's Coinsurance | 20% | Not Applicable |
| | Individual OOP Max | $8,150 | Not Applicable |
| | Family OOP Max | $16,300 | Not Applicable |
| Preventive Care | Preventive Care/Screening/Immunization | No Charge | Not Covered |
| | Well Baby Visits and Care | No Charge | Not Covered |
| Office Visits | Primary Care Visit to Treat an Injury or Illness | $30 | Not Covered |
| | Specialist Visit | $65 after deductible | Not Covered |
| | Virtual Care Services | $0 | Not Covered |
| | Mental/Behavioral Health Outpatient Services | $30 | Not Covered |
| | Substance Abuse Disorder Outpatient Services | $30 | Not Covered |
| | Other Practitioner Office Visit | $30 | Not Covered |
| Emergency Care | Urgent Care Centers or Facilities | $75 | $75* |
| | Emergency Room Services | 20% Coinsurance after deductible | 20% Coinsurance after deductible* |
| | Emergency Transportation/Ambulance | 20% Coinsurance after deductible | 20% Coinsurance after deductible* |
| Laboratory and Imaging | Laboratory Outpatient and Professional Services | 20% Coinsurance after deductible | Not Covered |
| | X-rays and Diagnostic Imaging | 20% Coinsurance after deductible | Not Covered |
| | Imaging (CT/PET Scans, MRIs) | 20% Coinsurance after deductible | Not Covered |
| Maternity Care | Prenatal Office Visits | No Charge | Not Covered |
| | All Other Maternity Care | 20% Coinsurance after deductible | Not Covered |
| Hospital - Outpatient | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | 20% Coinsurance after deductible | Not Covered |
| | Outpatient Surgery Physician/Surgical Services | 20% Coinsurance after deductible | Not Covered |

| Category | Service | In Network | Out of Network |
|---|---|---|---|
| Hospital - Inpatient | Inpatient Hospital Services (e.g., Hospital Stay) | 20% Coinsurance after deductible | Not Covered |
| | Inpatient Physician and Surgical Services | 20% Coinsurance after deductible | Not Covered |
| | Mental/Behavioral Health Inpatient Services | 20% Coinsurance after deductible | Not Covered |
| | Substance Abuse Disorder Inpatient Services | 20% Coinsurance after deductible | Not Covered |
| Surgery | Reconstructive Surgery | 20% Coinsurance after deductible | Not Covered |
| | Bariatric Surgery | 20% Coinsurance after deductible | Not Covered |
| | Transplant | 20% Coinsurance after deductible | Not Covered |
| | Treatment for Temporomandibular Joint Disorders | 20% Coinsurance after deductible | Not Covered |
| | Accidental Dental | 20% Coinsurance after deductible | Not Covered |
| Home Health Care | Home Health Care Services | 20% Coinsurance after deductible | Not Covered |
| | Hospice Services | 20% Coinsurance after deductible | Not Covered |
| | Habilitation Services | 20% Coinsurance after deductible | Not Covered |
| | Skilled Nursing Facility | 20% Coinsurance after deductible | Not Covered |
| Autism Treatment | Outpatient Mental Health Services to Treat Autism | $30 | Not Covered |
| | Habilitation Services to Treat Autism | 20% Coinsurance after deductible | Not Covered |
| Other Services | Chiropractic Care | 20% Coinsurance after deductible | Not Covered |
| | Diabetes Education | 20% Coinsurance after deductible | Not Covered |
| | Allergy Testing | 20% Coinsurance after deductible | Not Covered |
| | Routine Eye Exam (Adult) | 20% Coinsurance after deductible | Not Covered |
| | Routine Eye Exam for Children | 20% Coinsurance after deductible | Not Covered |
| | Eye Glasses for Children | 20% Coinsurance after deductible | Not Covered |
| | Infertility Treatment | 20% Coinsurance after deductible | Not Covered |
| | Weight Loss Programs | 20% Coinsurance after deductible | Not Covered |
| | Chemotherapy | 20% Coinsurance after deductible | Not Covered |
| | Dialysis | 20% Coinsurance after deductible | Not Covered |
| | Durable Medical Equipment | 20% Coinsurance after deductible | Not Covered |
| | Infusion Therapy | 20% Coinsurance after deductible | Not Covered |
| | Outpatient Rehabilitation Services | 20% Coinsurance after deductible | Not Covered |
| | Prosthetic Devices | 20% Coinsurance after deductible | Not Covered |

| Category | Service | In Network | Out of Network |
|---|---|---|---|
| Other Services | **Radiation** | 20% Coinsurance after deductible | Not Covered |
| | **Rehabilitative Occupational and Rehabilitative Physical Therapy** | 20% Coinsurance after deductible | Not Covered |
| | **Rehabilitative Speech Therapy** | 20% Coinsurance after deductible | Not Covered |
| | **Prescription Drugs Other** | 20% Coinsurance after deductible | Not Covered |
| | **Mental Health Other** | 20% Coinsurance after deductible | Not Covered |
| | | **Rx Deductible - $500** | |
| Prescription Drugs | **Generic Drugs** | $10 | Not Covered |
| | **Preferred Brand Drugs** | $75 | Not Covered |
| | **Non-Preferred Brand Drugs** | $125 | Not Covered |
| | **Specialty Drugs** | 40%** | Not Covered |
| **Subject to the Rx Deductible | | | |
| * 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:

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