McLaren
HEALTH PLAN COMMUNITY

Plan Year		2023	
Plan Name		McLaren Gold HSA 1750 Plan	
Market		Small Group	
Category	**Service**	**In Network**	**Out of Network**
General Plan Information	Individual Deductible	$1,750	Not Applicable
	Family Deductible	$3,500	Not Applicable
	Member's Coinsurance	20%	Not Applicable
	Individual OOP Max	$3,000	Not Applicable
	Family OOP Max	$6,000	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	20% Coinsurance after deductible	Not Covered
	Specialist Visit	20% Coinsurance after deductible	Not Covered
	Mental/Behavioral Health Outpatient Services	20% Coinsurance after deductible	Not Covered
	Substance Abuse Disorder Outpatient Services	20% Coinsurance after deductible	Not Covered
	Other Practitioner Office Visit	20% Coinsurance after deductible	Not Covered
Emergency Care	Urgent Care Centers or Facilities	20% Coinsurance after deductible	20% Coinsurance after deductible
	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
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

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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**	20% Coinsurance after deductible	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
	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
Prescription Drugs	**Generic Drugs**	$25 after deductible	Not Covered
	Preferred Brand Drugs	$75 after deductible	Not Covered
	Non-Preferred Brand Drugs	$100 after deductible	Not Covered
	Specialty Drugs	Deductible and Coinsurance Max $300	Not Covered

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).