McLaren
HEALTH PLAN COMMUNITY

Plan Year		2023		
Plan Name		McLaren Rewards Silver Plan		
Market		Small Group		
Category	Service	In Network		Out of Network
		MHPC Directly Contracted	Rewards	
General Plan Information	Individual Deductible	$9,100	None	Not Applicable
	Family Deductible	$18,200	None	Not Applicable
	Member's Coinsurance	0%	None	Not Applicable
	Individual OOP Max	$9,100		Not Applicable
	Family OOP Max	$18,200		Not Applicable
Preventive Care	Preventive Care/Screening/Immunization	No Charge	No Charge	Not Covered
	Well Baby Visits and Care	No Charge	No Charge	Not Covered
Office Visits	Primary Care Visit to Treat an Injury or Illness	0% Coinsurance after deductible	No Charge	Not Covered
	Specialist Visit	0% Coinsurance after deductible	No Charge	Not Covered
	Mental/Behavioral Health Outpatient Services	0% Coinsurance after deductible	No Charge	Not Covered
	Substance Abuse Disorder Outpatient Services	0% Coinsurance after deductible	No Charge	Not Covered
	Other Practitioner Office Visit	0% Coinsurance after deductible	No Charge	Not Covered
Emergency Care	Urgent Care Centers or Facilities	0% Coinsurance after deductible	No Charge	0% Coinsurance after deductible
	Emergency Room Services	0% Coinsurance after deductible	No Charge	0% Coinsurance after deductible
	Emergency Transportation/Ambulance	0% Coinsurance after deductible	No Charge	0% Coinsurance after deductible
Laboratory and Imaging	Laboratory Outpatient and Professional Services	0% Coinsurance after deductible	No Charge	Not Covered
	X-rays and Diagnostic Imaging	0% Coinsurance after deductible	No Charge	Not Covered
	Imaging (CT/PET Scans, MRIs)	0% Coinsurance after deductible	No Charge	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	No Charge	Not Covered
	All Other Maternity Care	0% Coinsurance after deductible	No Charge	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% Coinsurance after deductible	No Charge	Not Covered
	Outpatient Surgery Physician/Surgical Services	0% Coinsurance after deductible	No Charge	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	0% Coinsurance after deductible	No Charge	Not Covered
	Inpatient Physician and Surgical Services	0% Coinsurance after deductible	No Charge	Not Covered
	Mental/Behavioral Health Inpatient Services	0% Coinsurance after deductible	No Charge	Not Covered
	Substance Abuse Disorder Inpatient Services	0% Coinsurance after deductible	No Charge	Not Covered
Surgery	Reconstructive Surgery	0% Coinsurance after deductible	No Charge	Not Covered
	Bariatric Surgery	0% Coinsurance after deductible	No Charge	Not Covered
	Transplant	0% Coinsurance after deductible	No Charge	Not Covered
	Treatment for Temporomandibular Joint Disorders	0% Coinsurance after deductible	No Charge	Not Covered
	Accidental Dental	0% Coinsurance after deductible	No Charge	Not Covered

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Home Health Care	Home Health Care Services	0% Coinsurance after deductible	No Charge	Not Covered
	Hospice Services	0% Coinsurance after deductible	No Charge	Not Covered
	Habilitation Services	0% Coinsurance after deductible	No Charge	Not Covered
	Skilled Nursing Facility	0% Coinsurance after deductible	No Charge	Not Covered
Autism Treatment	Outpatient Mental Health Services to Treat Autism	0% Coinsurance after deductible	No Charge	Not Covered
	Habilitation Services to Treat Autism	0% Coinsurance after deductible	No Charge	Not Covered
Other Services	Chiropractic Care	0% Coinsurance after deductible	No Charge	Not Covered
	Diabetes Education	0% Coinsurance after deductible	No Charge	Not Covered
	Allergy Testing	0% Coinsurance after deductible	No Charge	Not Covered
	Routine Eye Exam (Adult)	0% Coinsurance after deductible	No Charge	Not Covered
	Routine Eye Exam for Children	0% Coinsurance after deductible	No Charge	Not Covered
	Eye Glasses for Children	0% Coinsurance after deductible	No Charge	Not Covered
	Infertility Treatment	0% Coinsurance after deductible	No Charge	Not Covered
	Weight Loss Programs	0% Coinsurance after deductible	No Charge	Not Covered
	Chemotherapy	0% Coinsurance after deductible	No Charge	Not Covered
	Dialysis	0% Coinsurance after deductible	No Charge	Not Covered
	Durable Medical Equipment	0% Coinsurance after deductible	No Charge	Not Covered
	Infusion Therapy	0% Coinsurance after deductible	No Charge	Not Covered
	Outpatient Rehabilitation Services	0% Coinsurance after deductible	No Charge	Not Covered
	Prosthetic Devices	0% Coinsurance after deductible	No Charge	Not Covered
	Radiation	0% Coinsurance after deductible	No Charge	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after deductible	No Charge	Not Covered
	Rehabilitative Speech Therapy	0% Coinsurance after deductible	No Charge	Not Covered
	Prescription Drugs Other	0% Coinsurance after deductible	No Charge	Not Covered
	Mental Health Other	0% Coinsurance after deductible	No Charge	Not Covered
Prescription Drugs	Generic Drugs	$35		Not Covered
	Preferred Brand Drugs	$125		Not Covered
	Non-Preferred Brand Drugs	50% Coinsurance		Not Covered
	Specialty Drugs	50% Coinsurance		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).