McLaren HEALTH PLAN COMMUNITY

| Plan Year | | 2023 | |
|---|---|---|---|
| Plan Name | | McLaren Silver 3500 VCP Plan | |
| Market | | Small Group | |
| **Category** | **Service** | **In Network** | **Out of Network** |
| General Plan Information | Individual Deductible | $3,500 | Not Applicable |
| | Family Deductible | $7,000 | Not Applicable |
| | Member's Coinsurance | 40% | Not Applicable |
| | Individual OOP Max | $8,750 | Not Applicable |
| | Family OOP Max | $17,500 | 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 | $45 | Not Covered |
| | Specialist Visit | $80 | Not Covered |
| | Virtual Care Services | $0 | Not Covered |
| | Mental/Behavioral Health Outpatient Services | $45 | Not Covered |
| | Substance Abuse Disorder Outpatient Services | $45 | Not Covered |
| | Other Practitioner Office Visit | $80 | Not Covered |
| Emergency Care | Urgent Care Centers or Facilities | $60 | $60 |
| | Emergency Room Services | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| | Emergency Transportation/Ambulance | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Laboratory and Imaging | Laboratory Outpatient and Professional Services | 40% Coinsurance after deductible | Not Covered |
| | X-rays and Diagnostic Imaging | 40% Coinsurance after deductible | Not Covered |
| | Imaging (CT/PET Scans, MRIs) | 40% Coinsurance after deductible | Not Covered |
| Maternity Care | Prenatal Office Visits | No Charge | Not Covered |
| | All Other Maternity Care | 40% Coinsurance after deductible | Not Covered |
| Hospital - Outpatient | Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | 40% Coinsurance after deductible | Not Covered |
| | Outpatient Surgery Physician/Surgical Services | 40% Coinsurance after deductible | Not Covered |
| Hospital - Inpatient | Inpatient Hospital Services (e.g., Hospital Stay) | 40% Coinsurance after deductible | Not Covered |
| | Inpatient Physician and Surgical Services | 40% Coinsurance after deductible | Not Covered |
| | Mental/Behavioral Health Inpatient Services | 40% Coinsurance after deductible | Not Covered |
| | Substance Abuse Disorder Inpatient Services | 40% Coinsurance after deductible | Not Covered |
| Surgery | Reconstructive Surgery | 40% Coinsurance after deductible | Not Covered |
| | Bariatric Surgery | 40% Coinsurance after deductible | Not Covered |
| | Transplant | 40% Coinsurance after deductible | Not Covered |
| | Treatment for Temporomandibular Joint Disorders | 40% Coinsurance after deductible | Not Covered |
| | Accidental Dental | 40% Coinsurance after deductible | Not Covered |

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| Home Health Care | Home Health Care Services | 40% Coinsurance after deductible | Not Covered |
| | Hospice Services | 40% Coinsurance after deductible | Not Covered |
| | Habilitation Services | 40% Coinsurance after deductible | Not Covered |
| | Skilled Nursing Facility | 40% Coinsurance after deductible | Not Covered |
| Autism Treatment | Outpatient Mental Health Services to Treat Autism | $45 | Not Covered |
| | Habilitation Services to Treat Autism | 40% Coinsurance after deductible | Not Covered |
| Other Services | Chiropractic Care | 40% Coinsurance after deductible | Not Covered |
| | Diabetes Education | 40% Coinsurance after deductible | Not Covered |
| | Allergy Testing | 40% Coinsurance after deductible | Not Covered |
| | Routine Eye Exam (Adult) | 40% Coinsurance after deductible | Not Covered |
| | Routine Eye Exam for Children | 40% Coinsurance after deductible | Not Covered |
| | Eye Glasses for Children | 40% Coinsurance after deductible | Not Covered |
| | Infertility Treatment | 40% Coinsurance after deductible | Not Covered |
| | Weight Loss Programs | 40% Coinsurance after deductible | Not Covered |
| | Chemotherapy | 40% Coinsurance after deductible | Not Covered |
| | Dialysis | 40% Coinsurance after deductible | Not Covered |
| | Durable Medical Equipment | 40% Coinsurance after deductible | Not Covered |
| | Infusion Therapy | 40% Coinsurance after deductible | Not Covered |
| | Outpatient Rehabilitation Services | 40% Coinsurance after deductible | Not Covered |
| | Prosthetic Devices | 40% Coinsurance after deductible | Not Covered |
| | Radiation | 40% Coinsurance after deductible | Not Covered |
| | Rehabilitative Occupational and Rehabilitative Physical Therapy | 40% Coinsurance after deductible | Not Covered |
| | Rehabilitative Speech Therapy | 40% Coinsurance after deductible | Not Covered |
| | Prescription Drugs Other | 40% Coinsurance after deductible | Not Covered |
| | Mental Health Other | 40% Coinsurance after deductible | Not Covered |
| Prescription Drugs | Generic Drugs | $30 | Not Covered |
| | Preferred Brand Drugs | $90 | Not Covered |
| | Non-Preferred Brand Drugs | $150 | Not Covered |
| | Specialty Drugs | $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).