McLaren
HEALTH PLAN COMMUNITY

Plan Year		2023	
Plan Name		McLaren Silver 3500 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
	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

Plan Year		2023	
Plan Name		McLaren Silver 3500 Plan	
Market		Small Group	
Category	**Service**	**In Network**	**Out of Network**
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).