



HEALTH PLAN COMMUNITY

Plan Year		2023	
Plan Name		McLaren Silver HSA 3000 Plan	
Market		Small Group	
Category	Service	In Network	Out of Network
General Plan Information	Individual Deductible	\$3,000	Not Applicable
	Family Deductible	\$6,000	Not Applicable
	Member's Coinsurance	30%	Not Applicable
	Individual OOP Max	\$6,000	Not Applicable
	Family OOP Max	\$12,000	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	30% Coinsurance after deductible	Not Covered
	Specialist Visit	30% Coinsurance after deductible	Not Covered
	Mental/Behavioral Health Outpatient Services	30% Coinsurance after deductible	Not Covered
	Substance Abuse Disorder Outpatient Services	30% Coinsurance after deductible	Not Covered
	Other Practitioner Office Visit	30% Coinsurance after deductible	Not Covered
Emergency Care	Urgent Care Centers or Facilities	30% Coinsurance after deductible	30% Coinsurance after deductible
	Emergency Room Services	30% Coinsurance after deductible	30% Coinsurance after deductible
	Emergency Transportation/Ambulance	30% Coinsurance after deductible	30% Coinsurance after deductible*
Laboratory and Imaging	Laboratory Outpatient and Professional Services	30% Coinsurance after deductible	Not Covered
	X-rays and Diagnostic Imaging	30% Coinsurance after deductible	Not Covered
	Imaging (CT/PET Scans, MRIs)	30% Coinsurance after deductible	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	Not Covered
	All Other Maternity Care	30% Coinsurance after deductible	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% Coinsurance after deductible	Not Covered
	Outpatient Surgery Physician/Surgical Services	30% Coinsurance after deductible	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	30% Coinsurance after deductible	Not Covered
	Inpatient Physician and Surgical Services	30% Coinsurance after deductible	Not Covered
	Mental/Behavioral Health Inpatient Services	30% Coinsurance after deductible	Not Covered
	Substance Abuse Disorder Inpatient Services	30% Coinsurance after deductible	Not Covered
Surgery	Reconstructive Surgery	30% Coinsurance after deductible	Not Covered
	Bariatric Surgery	30% Coinsurance after deductible	Not Covered
	Transplant	30% Coinsurance after deductible	Not Covered
	Treatment for Temporomandibular Joint Disorders	30% Coinsurance after deductible	Not Covered
	Accidental Dental	30% Coinsurance after deductible	Not Covered

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Home Health Care	Home Health Care Services	30% Coinsurance after deductible	Not Covered
	Hospice Services	30% Coinsurance after deductible	Not Covered
	Habilitation Services	30% Coinsurance after deductible	Not Covered
	Skilled Nursing Facility	30% Coinsurance after deductible	Not Covered
Autism Treatment	Outpatient Mental Health Services to Treat Autism	30% Coinsurance after deductible	Not Covered
	Habilitation Services to Treat Autism	30% Coinsurance after deductible	Not Covered
Other Services	Chiropractic Care	30% Coinsurance after deductible	Not Covered
	Diabetes Education	30% Coinsurance after deductible	Not Covered
	Allergy Testing	30% Coinsurance after deductible	Not Covered
	Routine Eye Exam (Adult)	30% Coinsurance after deductible	Not Covered
	Routine Eye Exam for Children	30% Coinsurance after deductible	Not Covered
	Eye Glasses for Children	30% Coinsurance after deductible	Not Covered
	Infertility Treatment	30% Coinsurance after deductible	Not Covered
	Weight Loss Programs	30% Coinsurance after deductible	Not Covered
	Chemotherapy	30% Coinsurance after deductible	Not Covered
	Dialysis	30% Coinsurance after deductible	Not Covered
	Durable Medical Equipment	30% Coinsurance after deductible	Not Covered
	Infusion Therapy	30% Coinsurance after deductible	Not Covered
	Outpatient Rehabilitation Services	30% Coinsurance after deductible	Not Covered
	Prosthetic Devices	30% Coinsurance after deductible	Not Covered
	Radiation	30% Coinsurance after deductible	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance after deductible	Not Covered
	Rehabilitative Speech Therapy	30% Coinsurance after deductible	Not Covered
	Prescription Drugs Other	30% Coinsurance after deductible	Not Covered
	Mental Health Other	30% Coinsurance after deductible	Not Covered
Prescription Drugs	Generic Drugs	\$35 after deductible	Not Covered
	Preferred Brand Drugs	\$85 after deductible	Not Covered
	Non-Preferred Brand Drugs	\$125 after deductible	Not Covered
	Specialty Drugs	30% coinsurance after deductible Max \$350	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).