



HEALTH PLAN COMMUNITY

| Plan Year                |   | 2019                             |                                   |
|--------------------------|---|----------------------------------|-----------------------------------|
| Plan Name                |   | McLaren Gold 1250 Plan           |                                   |
| Market                   |   | Small Group                      |                                   |
| Category                 | Service   | In Network                       | Out of Network                    |
|                          |   | MHPC Directly Contracted         |                                   |
| General Plan Information | Individual Deductible                                     | \$1,250                          | Not Applicable                    |
|                          | Family Deductible   | \$2,500                          | Not Applicable                    |
|                          | Member's Coinsurance                                      | 20%                              | Not Applicable                    |
|                          | Individual OOP Max  | \$4,800                          | Not Applicable                    |
|                          | Family OOP Max  | \$9,600                          | 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                             | Not Covered                       |
|                          | Specialist Visit  | \$60                             | Not Covered                       |
|                          | Mental/Behavioral Health Outpatient Services              | \$30                             | Not Covered                       |
|                          | Substance Abuse Disorder Outpatient Services              | \$30                             | Not Covered                       |
|                          | Other Practitioner Office Visit                           | \$60                             | Not Covered                       |
| Emergency Care           | Urgent Care Centers or Facilities                         | \$60                             | \$60*                             |
|                          | Emergency Room Services                                   | \$250                            | \$250*                            |
|                          | 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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|                          |   | MHPC Directly Contracted         |                |
| 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               | \$30                             | 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   | \$20                             | Not Covered    |
|                          | Preferred Brand Drugs   | \$40                             | Not Covered    |
|                          | Non-Preferred Brand Drugs                                       | \$200                            | Not Covered    |
|                          | Specialty Drugs   | \$300                            | Not Covered    |

\* Balance billed amounts charged by the provider are the responsibility of the member

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)