McLaren
HEALTH PLAN COMMUNITY

Plan Year		2018	
Plan Name		Bronze HSA 6550 Plan	
Market		Small Group	
Category	Service	In Network MHPC Directly Contracted	Out of Network
General Plan Information	Individual Deductible	$6,550	Not Applicable
	Family Deductible	$13,100	Not Applicable
	Member's Coinsurance	0%	Not Applicable
	Individual OOP Max	$6,550	Not Applicable
	Family OOP Max	$13,100	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	No charge after deductible	Not Covered
	Specialist Visit	No charge after deductible	Not Covered
	Mental/Behavioral Health Outpatient Services	No charge after deductible	Not Covered
	Substance Abuse Disorder Outpatient Services	No charge after deductible	Not Covered
	Other Practitioner Office Visit	No charge after deductible	Not Covered
Emergency Care	Urgent Care Centers or Facilities	No charge after deductible	No charge after deductible*
	Emergency Room Services	No charge after deductible	No charge after deductible*
	Emergency Transportation/Ambulance	No charge after deductible	No charge after deductible*
Laboratory and Imaging	Laboratory Outpatient and Professional Services	No charge after deductible	Not Covered
	X-rays and Diagnostic Imaging	No charge after deductible	Not Covered
	Imaging (CT/PET Scans, MRIs)	No charge after deductible	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	Not Covered
	All Other Maternity Care	No charge after deductible	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No charge after deductible	Not Covered
	Outpatient Surgery Physician/Surgical Services	No charge after deductible	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	No charge after deductible	Not Covered
	Inpatient Physician and Surgical Services	No charge after deductible	Not Covered
	Mental/Behavioral Health Inpatient Services	No charge after deductible	Not Covered
	Substance Abuse Disorder Inpatient Services	No charge after deductible	Not Covered
Surgery	Reconstructive Surgery	No charge after deductible	Not Covered
	Bariatric Surgery	No charge after deductible	Not Covered
	Transplant	No charge after deductible	Not Covered
	Treatment for Temporomandibular Joint Disorders	No charge after deductible	Not Covered
	Accidental Dental	No charge after deductible	Not Covered

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