McLaren
HEALTH PLAN COMMUNITY

Plan Year		2018	
Plan Name		Gold HRA 4500 Plan	
Market		Small Group	
Employer Contribution to HRA		$500	
Category	Service	In Network MHPC Directly Contracted	Out of Network
General Plan Information	Individual Deductible	$4,500	Not Applicable
	Family Deductible	$9,000	Not Applicable
	Member's Coinsurance	30%	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	$20	Not Covered
	Specialist Visit	$40	Not Covered
	Mental/Behavioral Health Outpatient Services	$20	Not Covered
	Substance Abuse Disorder Outpatient Services	$20	Not Covered
	Other Practitioner Office Visit	$40	Not Covered
Emergency Care	Urgent Care Centers or Facilities	$60	$60*
	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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Category	Service	In Network MHPC Directly Contracted	Out of Network
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	$10	Not Covered
	Preferred Brand Drugs	$30	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).