McLaren
HEALTH PLAN COMMUNITY

Plan Year		2018		
Plan Name		Platinum Reward Plan		
Market		Small Group		
Category	Service	In Network		Out of Network
		MHPC Directly Contracted	Rewards	
General Plan Information	Individual Deductible	$500	None	Not Applicable
	Family Deductible	$1,000	None	Not Applicable
	Member's Coinsurance	10%	None	Not Applicable
	Individual OOP Max	$2,000		Not Applicable
	Family OOP Max	$4,000		Not Applicable
Preventive Care	Preventive Care/Screening/Immunization	No Charge	No Charge	Not Covered
	Well Baby Visits and Care	No Charge	No Charge	Not Covered
Office Visits	Primary Care Visit to Treat an Injury or Illness	$25	No Charge	Not Covered
	Specialist Visit	$50	No Charge	Not Covered
	Mental/Behavioral Health Outpatient Services	$25	No Charge	Not Covered
	Substance Abuse Disorder Outpatient Services	$25	No Charge	Not Covered
	Other Practitioner Office Visit	$50	No Charge	Not Covered
Emergency Care	Urgent Care Centers or Facilities	$60	No Charge	$60*
	Emergency Room Services	$250	No Charge	$250*
	Emergency Transportation/Ambulance	10% Coinsurance after deductible	No Charge	10% Coinsurance after deductible*
Laboratory and Imaging	Laboratory Outpatient and Professional Services	10% Coinsurance after deductible	No Charge	Not Covered
	X-rays and Diagnostic Imaging	10% Coinsurance after deductible	No Charge	Not Covered
	Imaging (CT/PET Scans, MRIs)	10% Coinsurance after deductible	No Charge	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	No Charge	Not Covered
	All Other Maternity Care	10% Coinsurance after deductible	No Charge	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% Coinsurance after deductible	No Charge	Not Covered
	Outpatient Surgery Physician/Surgical Services	10% Coinsurance after deductible	No Charge	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	10% Coinsurance after deductible	No Charge	Not Covered
	Inpatient Physician and Surgical Services	10% Coinsurance after deductible	No Charge	Not Covered
	Mental/Behavioral Health Inpatient Services	10% Coinsurance after deductible	No Charge	Not Covered
	Substance Abuse Disorder Inpatient Services	10% Coinsurance after deductible	No Charge	Not Covered
Surgery	Reconstructive Surgery	10% Coinsurance after deductible	No Charge	Not Covered
	Bariatric Surgery	10% Coinsurance after deductible	No Charge	Not Covered
	Transplant	10% Coinsurance after deductible	No Charge	Not Covered
	Treatment for Temporomandibular Joint Disorders	10% Coinsurance after deductible	No Charge	Not Covered
	Accidental Dental	10% Coinsurance after deductible	No Charge	Not Covered

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Home Health Care	Home Health Care Services	10% Coinsurance after deductible	No Charge	Not Covered
	Hospice Services	10% Coinsurance after deductible	No Charge	Not Covered
	Habilitation Services	10% Coinsurance after deductible	No Charge	Not Covered
	Skilled Nursing Facility	10% Coinsurance after deductible	No Charge	Not Covered
Autism Treatment	Outpatient Mental Health Services to Treat Autism	$25	No Charge	Not Covered
	Habilitation Services to Treat Autism	10% Coinsurance after deductible	No Charge	Not Covered
Other Services	Chiropractic Care	10% Coinsurance after deductible	No Charge	Not Covered
	Diabetes Education	10% Coinsurance after deductible	No Charge	Not Covered
	Allergy Testing	10% Coinsurance after deductible	No Charge	Not Covered
	Routine Eye Exam (Adult)	10% Coinsurance after deductible	No Charge	Not Covered
	Routine Eye Exam for Children	10% Coinsurance after deductible	No Charge	Not Covered
	Eye Glasses for Children	10% Coinsurance after deductible	No Charge	Not Covered
	Infertility Treatment	10% Coinsurance after deductible	No Charge	Not Covered
	Weight Loss Programs	10% Coinsurance after deductible	No Charge	Not Covered
	Chemotherapy	10% Coinsurance after deductible	No Charge	Not Covered
	Dialysis	10% Coinsurance after deductible	No Charge	Not Covered
	Durable Medical Equipment	10% Coinsurance after deductible	No Charge	Not Covered
	Infusion Therapy	10% Coinsurance after deductible	No Charge	Not Covered
	Outpatient Rehabilitation Services	10% Coinsurance after deductible	No Charge	Not Covered
	Prosthetic Devices	10% Coinsurance after deductible	No Charge	Not Covered
	Radiation	10% Coinsurance after deductible	No Charge	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	10% Coinsurance after deductible	No Charge	Not Covered
	Rehabilitative Speech Therapy	10% Coinsurance after deductible	No Charge	Not Covered
	Prescription Drugs Other	10% Coinsurance after deductible	No Charge	Not Covered
	Mental Health Other	10% Coinsurance after deductible	No Charge	Not Covered
Prescription Drugs	Generic Drugs	$5		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).