Plan Year		2023	
Plan Name		McLaren Gold Standard	
Market		Individual - Off Exchange Only	
Category	**Service**	**In Network**	**Out of Network**
General Plan Information	Individual Deductible	$2,000	Not Applicable
	Family Deductible	$4,000	Not Applicable
	Member's Coinsurance	25%	Not Applicable
	Individual OOP Max	$8,700	Not Applicable
	Family OOP Max	$17,400	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	$30	Not Covered
Emergency Care	Urgent Care Centers or Facilities	$45	$45
	Emergency Room Services	25% Coinsurance after Deductible	25% Coinsurance after Deductible
	Emergency Transportation/Ambulance	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Laboratory and Imaging	Laboratory Outpatient and Professional Services	25% Coinsurance after Deductible	Not Covered
	X-rays and Diagnostic Imaging	25% Coinsurance after Deductible	Not Covered
	Imaging (CT/PET Scans, MRIs)	25% Coinsurance after Deductible	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	Not Covered
	All Other Maternity Care	25% Coinsurance after Deductible	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	25% Coinsurance after Deductible	Not Covered
	Outpatient Surgery Physician/Surgical Services	25% Coinsurance after Deductible	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	25% Coinsurance after Deductible	Not Covered
	Inpatient Physician and Surgical Services	25% Coinsurance after Deductible	Not Covered
	Mental/Behavioral Health Inpatient Services	25% Coinsurance after Deductible	Not Covered
	Substance Abuse Disorder Inpatient Services	25% Coinsurance after Deductible	Not Covered
Surgery	Reconstructive Surgery	25% Coinsurance after Deductible	Not Covered
	Bariatric Surgery	25% Coinsurance after Deductible	Not Covered
	Transplant	25% Coinsurance after Deductible	Not Covered
	Treatment for Temporomandibular Joint Disorders	25% Coinsurance after Deductible	Not Covered
	Accidental Dental	25% Coinsurance after Deductible	Not Covered

Category	Service	In Network	Out of Network
Home Health Care	**Home Health Care Services**	25% Coinsurance after Deductible	Not Covered
	Hospice Services	25% Coinsurance after Deductible	Not Covered
	Habilitation Services	25% Coinsurance after Deductible	Not Covered
	Skilled Nursing Facility	25% Coinsurance after Deductible	Not Covered
Autism Treatment	**Outpatient Mental Health Services to Treat Autism**	$30	Not Covered
	Habilitation Services to Treat Autism	25% Coinsurance after Deductible	Not Covered
Other Services	**Chiropractic Care**	25% Coinsurance after Deductible	Not Covered
	Diabetes Education	25% Coinsurance after Deductible	Not Covered
	Allergy Testing	25% Coinsurance after Deductible	Not Covered
	Routine Eye Exam (Adult)	25% Coinsurance after Deductible	Not Covered
	Routine Eye Exam for Children	25% Coinsurance after Deductible	Not Covered
	Eye Glasses for Children	25% Coinsurance after Deductible	Not Covered
	Infertility Treatment	25% Coinsurance after Deductible	Not Covered
	Weight Loss Programs	25% Coinsurance after Deductible	Not Covered
	Chemotherapy	25% Coinsurance after Deductible	Not Covered
	Dialysis	25% Coinsurance after Deductible	Not Covered
	Durable Medical Equipment	25% Coinsurance after Deductible	Not Covered
	Infusion Therapy	25% Coinsurance after Deductible	Not Covered
	Outpatient Rehabilitation Services	25% Coinsurance after Deductible	Not Covered
	Prosthetic Devices	25% Coinsurance after Deductible	Not Covered
	Radiation	25% Coinsurance after Deductible	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	$30	Not Covered
	Rehabilitative Speech Therapy	$30	Not Covered
	Prescription Drugs Other	25% Coinsurance after Deductible	Not Covered
	Mental Health Other	25% Coinsurance after Deductible	Not Covered
Prescription Drugs	**Generic Drugs**	$15	Not Covered
	Preferred Brand Drugs	$30	Not Covered
	Non-Preferred Brand Drugs	$60	Not Covered
	Specialty Drugs	$250	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).