McLaren
HEALTH PLAN COMMUNITY

Plan Year		2023	
Plan Name		McLaren Silver Standard	
Market		Individual - Off Exchange Only	
Category	**Service**	**In Network**	**Out of Network**
General Plan Information	Individual Deductible	$5,800	Not Applicable
	Family Deductible	$11,600	Not Applicable
	Member's Coinsurance	40%	Not Applicable
	Individual OOP Max	$8,900	Not Applicable
	Family OOP Max	$17,800	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	$40	Not Covered
	Specialist Visit	$80	Not Covered
	Mental/Behavioral Health Outpatient Services	$40	Not Covered
	Substance Abuse Disorder Outpatient Services	$40	Not Covered
	Other Practitioner Office Visit	$40	Not Covered
Emergency Care	Urgent Care Centers or Facilities	$60	$60
	Emergency Room Services	40% Coinsurance after Deductible	40% Coinsurance after Deductible
	Emergency Transportation/Ambulance	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory and Imaging	Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	Not Covered
	X-rays and Diagnostic Imaging	40% Coinsurance after Deductible	Not Covered
	Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible	Not Covered
Maternity Care	Prenatal Office Visits	No Charge	Not Covered
	All Other Maternity Care	40% Coinsurance after Deductible	Not Covered
Hospital - Outpatient	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40% Coinsurance after Deductible	Not Covered
	Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible	Not Covered
Hospital - Inpatient	Inpatient Hospital Services (e.g., Hospital Stay)	40% Coinsurance after Deductible	Not Covered
	Inpatient Physician and Surgical Services	40% Coinsurance after Deductible	Not Covered
	Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible	Not Covered
	Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible	Not Covered
Surgery	Reconstructive Surgery	40% Coinsurance after Deductible	Not Covered
	Bariatric Surgery	40% Coinsurance after Deductible	Not Covered
	Transplant	40% Coinsurance after Deductible	Not Covered
	Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible	Not Covered
	Accidental Dental	40% Coinsurance after Deductible	Not Covered

Category	Service	In Network	Out of Network
Home Health Care	Home Health Care Services	40% Coinsurance after Deductible	Not Covered
	Hospice Services	40% Coinsurance after Deductible	Not Covered
	Habilitation Services	40% Coinsurance after Deductible	Not Covered
	Skilled Nursing Facility	40% Coinsurance after Deductible	Not Covered
Autism Treatment	Outpatient Mental Health Services to Treat Autism	$40	Not Covered
	Habilitation Services to Treat Autism	40% Coinsurance after Deductible	Not Covered
Other Services	Chiropractic Care	40% Coinsurance after Deductible	Not Covered
	Diabetes Education	40% Coinsurance after Deductible	Not Covered
	Allergy Testing	40% Coinsurance after Deductible	Not Covered
	Routine Eye Exam (Adult)	40% Coinsurance after Deductible	Not Covered
	Routine Eye Exam for Children	40% Coinsurance after Deductible	Not Covered
	Eye Glasses for Children	40% Coinsurance after Deductible	Not Covered
	Infertility Treatment	40% Coinsurance after Deductible	Not Covered
	Weight Loss Programs	40% Coinsurance after Deductible	Not Covered
	Chemotherapy	40% Coinsurance after Deductible	Not Covered
	Dialysis	40% Coinsurance after Deductible	Not Covered
	Durable Medical Equipment	40% Coinsurance after Deductible	Not Covered
	Infusion Therapy	40% Coinsurance after Deductible	Not Covered
	Outpatient Rehabilitation Services	40% Coinsurance after Deductible	Not Covered
	Prosthetic Devices	40% Coinsurance after Deductible	Not Covered
	Radiation	40% Coinsurance after Deductible	Not Covered
	Rehabilitative Occupational and Rehabilitative Physical Therapy	$40	Not Covered
	Rehabilitative Speech Therapy	$40	Not Covered
	Prescription Drugs Other	40% Coinsurance after Deductible	Not Covered
	Mental Health Other	40% Coinsurance after Deductible	Not Covered
Prescription Drugs	Generic Drugs	$20	Not Covered
	Preferred Brand Drugs	$40	Not Covered
	Non-Preferred Brand Drugs	$80 copay after deductible	Not Covered
	Specialty Drugs	$350 copay after deductible	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).