MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO - HRA PLATINUM 1500

SCHEDULE OF COPAYMENTS AND DEDUCTIBLES

This document is a part of your Certificate of Coverage. It provides information about your financial responsibility with respect to your MHP Community Benefits. Please review the detailed chart below for information specific to each Covered Service.

Deductible	Out of Pocket Maximum	
\$1,500 Individual	\$6,550 Individual	
\$3,000 Family	\$13,100 Family	
		Out-of-Network
Medical	In-Network Member	Member Financial
Service	Financial Responsibility	Responsibility
Preventive Services	\$0	100% - No Coverage
Diabetic Services	20% Coinsurance and Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$20 Copayment No Deductible	100% - No Coverage
Specialist Office Visit	\$40 Copayment No Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – 20% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	20% Coinsurance and Deductible	100% - No Coverage
Spinal Treatment	20% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$60 Copayment No Deductible	\$60 Copayment plus Balance Billing No Deductible
Ambulance	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	20% Coinsurance and Deductible	100% - No Coverage

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Outpatient Hospital	20% Coinsurance and	100% - No Coverage
Services Diagnostic and	Deductible	4000/ Na Carrage
Diagnostic and	20% Coinsurance and	100% - No Coverage
Therapeutic Services	Deductible	
and Tests (other than Preventive Services)		
,	20% Coinsurance and	1009/ No Coverage
Organ and Tissue	Deductible	100% - No Coverage
Transplants Special Surgical	20% Coinsurance and	100% - No Coverage
Procedures	Deductible	100 % - No Coverage
Breast Reconstruction	20% Coinsurance and	100% - No Coverage
Following Mastectomy	Deductible	100% - No Coverage
Skilled Nursing Facility	20% Coinsurance and	100% - No Coverage
Services	Deductible	100% - No Coverage
Home Care Services	20% Coinsurance and	100% - No Coverage
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Hospice Care	20% Coinsurance and	100% - No Coverage
l respies sais	Deductible	10070 110 00101490
Outpatient Mental	\$20 Copayment	100% - No Coverage
Health Services	No Deductible	100,001100010.0.90
Inpatient Mental Health	20% Coinsurance and	100% - No Coverage
Services	Deductible	3
Emergency Mental	20% Coinsurance and	20% Coinsurance and
Health Services	Deductible	Deductible plus Balance
		Billing
Outpatient Substance	\$20 Copayment	100% - No Coverage
Abuse Services	No Deductible	
Inpatient Substance	20% Coinsurance and	100% - No Coverage
Abuse Services	Deductible	
Emergency Substance	20% Coinsurance and	20% Coinsurance and
Abuse Services	Deductible	Deductible plus Balance
	2001.0	Billing
Outpatient Habilitative	20% Coinsurance and	100% - No Coverage
Services	Deductible	1000/ N 0
Outpatient	20% Coinsurance and	100% - No Coverage
Rehabilitation	Deductible	4000/ NI= 0
Durable Medical	20% Coinsurance and	100% - No Coverage
Equipment (DME) and	Deductible	
Supplies Penroductive Core and	200/ Coincurance and	1009/ No Coverage
Reproductive Care and	20% Coinsurance and Deductible	100% - No Coverage
Family Planning Services	Deductible	
Pediatric Vision	20% Coinsurance and	100% - No Coverage
1 Guiatric Vision	Deductible	10070 - NO Coverage
Oral Surgery	20% Coinsurance and	100% - No Coverage
	Deductible	10070 140 Ooverage
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Temporomandibular Joint Syndrome (TMJ) Services	20% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	20% Coinsurance and Deductible	100% - No Coverage
Pain Management	20% Coinsurance and Deductible	100% - No Coverage
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	100% - No Coverage
Cancer Drug Therapy	20% Coinsurance and Deductible	100% - No Coverage
Educational Services	20% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. \$20 Copayment; No Deductible b. 20% Coinsurance and Deductible	100% - No Coverage
	Member Financial	
Pharmacy	Responsibility	Out-of-Network
Tier 1	\$10 Copayment No Deductible	100% - No Coverage
Tier 2	\$30 Copayment No Deductible	100% - No Coverage
Tier 3	\$200 Copayment No Deductible	100% - No Coverage
Specialty Drugs	\$300 Copayment No Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage