MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO - HRA PLATINUM 5000

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	
\$5,000 Individual	\$6,550 Individual	
\$10,000 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	30% Coinsurance and Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$40 Copayment No Deductible	100% - No Coverage
Specialist Office Visit	\$40 Copayment No Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	30% Coinsurance and Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – 30% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	30% Coinsurance and Deductible	100% - No Coverage
Spinal Treatment	30% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$60 Copayment No Deductible	\$60 Copayment plus Balance Billing No Deductible
Ambulance	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	30% Coinsurance and Deductible	100% - No Coverage

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Outpatient Hospital	30% Coinsurance and	100% - No Coverage
Services Diagnostic and	Deductible	1000/ No Covered
Diagnostic and	30% Coinsurance and Deductible	100% - No Coverage
Therapeutic Services and Tests (other than	Deductible	
Preventive Services)		
Organ and Tissue	30% Coinsurance and	100% - No Coverage
Transplants	Deductible	100% - No Coverage
Special Surgical	30% Coinsurance and	100% - No Coverage
Procedures	Deductible	100% - No Coverage
Breast Reconstruction	30% Coinsurance and	100% - No Coverage
Following Mastectomy	Deductible	10070 140 Coverage
Skilled Nursing Facility	30% Coinsurance and	100% - No Coverage
Services	Deductible	10070 110 00101ag0
Home Care Services	30% Coinsurance and	100% - No Coverage
Tromo dare dervices	Deductible	10070 110 00101ag0
Hospice Care	30% Coinsurance and	100% - No Coverage
l respies sais	Deductible	1.50% 1.15 25.15.1ag5
Outpatient Mental	\$40 Copayment	100% - No Coverage
Health Services	No Deductible	
Inpatient Mental Health	30% Coinsurance and	100% - No Coverage
Services	Deductible	
Emergency Mental	30% Coinsurance and	30% Coinsurance and
Health Services	Deductible	Deductible plus Balance
		Billing
Outpatient Substance	\$40 Copayment	100% - No Coverage
Abuse Services	No Deductible	
Inpatient Substance	30% Coinsurance and	100% - No Coverage
Abuse Services	Deductible	
Emergency Substance	30% Coinsurance and	30% Coinsurance and
Abuse Services	Deductible	Deductible plus Balance
	2004 0 :	Billing
Outpatient Habilitative	30% Coinsurance and	100% - No Coverage
Services	Deductible	4000/ N. O.
Outpatient	30% Coinsurance and	100% - No Coverage
Rehabilitation	Deductible 2004 Oniverse	4000/ No Oscione
Durable Medical	30% Coinsurance and	100% - No Coverage
Equipment (DME) and	Deductible	
Supplies Penroductive Care and	20% Coincurance and	1009/ No Coverage
Reproductive Care and Family Planning	30% Coinsurance and Deductible	100% - No Coverage
Services	Deductible	
Pediatric Vision	30% Coinsurance and	100% - No Coverage
1 Galattic Vision	Deductible	10070 140 Coverage
Oral Surgery	30% Coinsurance and	100% - No Coverage
	Deductible	10070 110 00101490
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Temporomandibular Joint Syndrome (TMJ) Services	30% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	30% Coinsurance and Deductible	100% - No Coverage
Pain Management	30% 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	30% Coinsurance and Deductible	100% - No Coverage
Educational Services	30% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. \$40 Copayment; No Deductible b. 30% Coinsurance and Deductible	100% - No Coverage
	Member Financial	
Pharmacy	Responsibility	Out-of-Network
Tier 1	\$20 Copayment No Deductible	100% - No Coverage
Tier 2	\$40 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