MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO - HSA PLATINUM 1350

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	
\$1,350 Individual	\$1,350 Individual	
\$2,700 Family	\$2,700 Family	
		Out-of-Network
Medical	In-Network Member	Member Financial
Service	Financial Responsibility	Responsibility
Preventive Services	\$0	100% - No Coverage
Diabetic Services	No charge after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	No charge after Deductible	100% - No Coverage
Specialist Office Visit	No charge after Deductible	100% - No Coverage
Immunizations (other	No charge after	100% - No Coverage
than Preventive Care)	Deductible	
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – No charge after Deductible	100% - No Coverage
Injectable Drugs Provided in the	No charge after Deductible	100% - No Coverage
Physician Office		
Spinal Treatment	No charge after Deductible	100% - No Coverage
Emergency Care –	No charge after	No charge after
Emergency Room	Deductible	Deductible but subject to Balance Billing
Urgent Care	No charge after	No charge after
	Deductible	Deductible but subject to Balance Billing
Ambulance	No charge after	No charge after
	Deductible	Deductible but subject to Balance Billing
Inpatient Hospital Service	No charge after Deductible	100% - No Coverage

Outpatient Hospital	No charge after	100% - No Coverage
Services	Deductible	
Diagnostic and	No oboveo ofter	1000/ No Coverage
Diagnostic and	No charge after	100% - No Coverage
Therapeutic Services	Deductible	
and Tests (other than		
Preventive Services)		10001 11 0
Organ and Tissue	No charge after	100% - No Coverage
Transplants	Deductible	
Special Surgical	No charge after	100% - No Coverage
Procedures	Deductible	
Breast Reconstruction	No charge after	100% - No Coverage
Following Mastectomy	Deductible	_
Skilled Nursing Facility	No charge after	100% - No Coverage
Services	Deductible	J
Home Care Services	No charge after	100% - No Coverage
	Deductible	
Hospice Care	No charge after	100% - No Coverage
Trespies Care	Deductible	10070 110 00101490
Outpatient Mental	No charge after	100% - No Coverage
Health Services	Deductible	10070 110 00101090
Inpatient Mental Health	No charge after	100% - No Coverage
Services	Deductible	10070 140 Coverage
Emergency Mental	No charge after	No charge after
Health Services	Deductible	Deductible but subject
Tieatti Services	Deddelible	to Balance Billing
Outpotiont Substance	No oborgo ofter	100% - No Coverage
Outpatient Substance Abuse Services	No charge after Deductible	100 % - No Coverage
	No charge after	100% No Coverage
Inpatient Substance		100% - No Coverage
Abuse Services	Deductible	No objects office
Emergency Substance	No charge after	No charge after
Abuse Services	Deductible	Deductible but subject
	N	to Balance Billing
Outpatient Habilitative	No charge after	100% - No Coverage
Services	Deductible	
Outpatient	No charge after	100% - No Coverage
Rehabilitation	Deductible	
Durable Medical	No charge after	100% - No Coverage
Equipment (DME) and	Deductible	
Supplies		
Reproductive Care and	No charge after	100% - No Coverage
Family Planning	Deductible	
Services		
Pediatric Vision	No charge after	100% - No Coverage
	Deductible	

Oral Surgery	No charge after Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	No charge after Deductible	100% - No Coverage
Orthognathic Surgery	No charge after Deductible	100% - No Coverage
Pain Management	No charge after 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	No charge after Deductible	100% - No Coverage
Educational Services	No charge after Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. No charge after Deductible b. No charge after Deductible	100% - No Coverage
	Member Financial	
Pharmacy	Responsibility	Out-of-Network
Tier 1	No charge after Deductible	100% - No Coverage
Tier 2	No charge after Deductible	100% - No Coverage
Tier 3	No charge after Deductible	100% - No Coverage
Specialty Drugs	No charge after Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage