MCLAREN HEALTH PLAN COMMUNITY

MCLAREN HMO – BRONZE

SCHEDULE OF COPAYMENTS AND DEDUCTIBLES

This document describes member costs associated with your Certificate of Coverage. This is a summary of some of the Benefits that you will receive and your share of the cost associated with the plan.

Deductible	Out of Pocket Maximum	
$5,500 Individual $11,000 Family	$7,350 Individual $14,700 Family	
Medical Service	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Preventive Services	$0	100% - No Coverage
Diabetic Services	50% Coinsurance and Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	50% Coinsurance and Deductible	100% - No Coverage
Specialist Office Visit	50% Coinsurance and Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	50% Coinsurance and Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits – $0 All other Maternity Care – 50% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	50% Coinsurance and Deductible	100% - No Coverage
Spinal Treatment	50% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	50% Coinsurance and Deductible	50% Coinsurance and Deductible plus Balance Billing
Urgent Care	50% Coinsurance and Deductible	50% Coinsurance and Deductible plus Balance Billing

Ambulance	50% Coinsurance and Deductible	50% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	50% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital Services	50% Coinsurance and Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	50% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	50% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	50% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	50% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	50% Coinsurance and Deductible	100% - No Coverage
Home Care Services	50% Coinsurance and Deductible	100% - No Coverage
Hospice Care	50% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	50% Coinsurance and Deductible	100% - No Coverage
Inpatient Mental Health Services	50% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	50% Coinsurance and Deductible	50% Coinsurance and Deductible plus Balance Billing
Outpatient Substance Abuse Services	50% Coinsurance and Deductible	100% - No Coverage
Inpatient Substance Abuse Services	50% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	50% Coinsurance and Deductible	50% Coinsurance and Deductible plus Balance Billing
Outpatient Habilitative Services	50% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation	50% Coinsurance and Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	50% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	50% Coinsurance and Deductible	100% - No Coverage
Pediatric Vision	50% Coinsurance and Deductible	100% - No Coverage

Oral Surgery	50% Coinsurance and Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	50% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	50% Coinsurance and Deductible	100% - No Coverage
Pain Management	50% 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	50% Coinsurance and Deductible	100% - No Coverage
Educational Services	50% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	50% Coinsurance and Deductible	100% - No Coverage
Pharmacy	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Tier 1	$30 Copayment No Deductible	100% - No Coverage
Tier 2	$70 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	$0	100% - No Coverage