## 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.

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

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

Oral Surgery	50% Coinsurance and	100% -
	Deductible	No Coverage
Temporomandibular Joint	50% Coinsurance and	100% -
Syndrome (TMJ) Services	Deductible	No Coverage
Orthognathic Surgery	50% Coinsurance and	100% -
	Deductible	No Coverage
Pain Management	50% Coinsurance and	100% -
	Deductible	No Coverage
Approved Clinical Trials	Member Cost Sharing	100% -
	_applicable to Routine	No Coverage
	Patient Costs outside of	
0 5 7	Approved Clinical Trial	1000/
Cancer Drug Therapy	50% Coinsurance and	100% -
Educational Comisso	Deductible	No Coverage
Educational Services	50% Coinsurance and	100% -
Aution Spectrum Digarder	Deductible 50% Coinsurance and	No Coverage 100% -
Autism Spectrum Disorder Services	Deductible	No Coverage
a. Outpatient Mental	Deductible	No Coverage
Health		
b. ABA (Habilitative)		
Services		
	In-Network	Out-of-Network
	Member Financial	Member Financial
Pharmacy	Responsibility	Responsibility
Tier 1	\$30 Copayment	100% -
	No Deductible	No Coverage
Tier 2	\$70 Copayment	100% -
	No Deductible	No Coverage
Tier 3	\$200 Copayment	100% -
	No Deductible	No Coverage
Specialty Drugs	\$300 Copayment	100% -
	No Deductible	No Coverage
Preventive	\$0	100% -
		No Coverage