MCLAREN HEALTH PLAN COMMUNITY

HMO STANDARD PLAN – SILVER

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	
\$3,500 Individual	\$7,350 Individual	
\$7,000 Family	\$14,700 Family	
Pharmacy Deductible		
\$500 Individual		
\$1,000 Family		
	In-Network Member	Out-of-Network
Medical	Financial	Member Financial
Service	Responsibility	Responsibility
Preventive Services	\$0	100% -
		No Coverage
Diabetic Services	20% Coinsurance	100% -
	and Deductible	No Coverage
Primary Care Physician	\$30 Copayment	100% -
(PCP) Office Visits	No Deductible	No Coverage
Specialist Office Visit	\$65 Copayment	100% -
	No Deductible	No Coverage
Immunizations (other than	20% Coinsurance	100% -
Preventive Care)	and Deductible	No Coverage
Maternity Care	Prenatal Office	100% -
	Visits – \$0	No Coverage
	All other Maternity Care –	
	20% Coinsurance and	
	Deductible	
Injectable Drugs Provided	20% Coinsurance	100% -
in the Physician Office	and Deductible	No Coverage
Spinal Treatment	20% Coinsurance	100% -
	and Deductible	No Coverage
Emergency Care –	20% Coinsurance	20% Coinsurance and
Emergency Room	and Deductible	Deductible plus Balance
		Billing
Urgent Care	\$75 Copayment	\$75 Copayment plus
	No Deductible	Balance Billing
		No Deductible

Ambulance	20% Coinsurance	20% Coinsurance and
	and Deductible	Deductible plus Balance
Investigat Heavital Comics	200/ Online une non	Billing
Inpatient Hospital Service	20% Coinsurance	100% -
O. 4 4 4. 1 4. 1.	and Deductible	No Coverage
Outpatient Hospital	20% Coinsurance	100% -
Services	and Deductible	No Coverage
Diagnostic and Therapeutic	20% Coinsurance	100% -
Services and Tests (other	and Deductible	No Coverage
than Preventive Services)	000/ 0 1	1000/
Organ and Tissue	20% Coinsurance	100% -
Transplants	and Deductible	No Coverage
Special Surgical	20% Coinsurance	100% -
Procedures	and Deductible	No Coverage
Breast Reconstruction	20% Coinsurance	100% -
Following Mastectomy	and Deductible	No Coverage
Skilled Nursing Facility	20% Coinsurance	100% -
Services	and Deductible	No Coverage
Home Care Services	20% Coinsurance	100% -
	and Deductible	No Coverage
Hospice Care	20% Coinsurance	100% -
	and Deductible	No Coverage
Outpatient Mental Health	\$30 Copayment	100% -
Services	No Deductible	No Coverage
Inpatient Mental Health	20% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Mental Health	20% Coinsurance	20% Coinsurance
Services	and Deductible	and Deductible plus
		Balance Billing
Outpatient Substance	\$30 Copayment	100% -
Abuse Services	No Deductible	No Coverage
Inpatient Substance Abuse	20% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Substance	20% Coinsurance	20% Coinsurance
Abuse Services	and Deductible	and Deductible plus
		Balance Billing
Outpatient Habilitative	20% Coinsurance	100% -
Services	and Deductible	No Coverage
Outpatient Rehabilitation	20% Coinsurance	100% -
	and Deductible	No Coverage
Durable Medical Equipment	20% Coinsurance	100% -
(DME)	and Deductible	No Coverage
And Supplies		_
Reproductive Care and	20% Coinsurance	100% -
Family Planning Services	and Deductible	No Coverage

Pediatric Vision	20% Coinsurance	100% -
T calatile vision	and Deductible	No Coverage
Oral Surgery	20% Coinsurance	100% -
	and Deductible	No Coverage
Temporomandibular Joint	20% Coinsurance	100% -
Syndrome (TMJ) Services	and Deductible	No Coverage
Orthognathic Surgery	20% Coinsurance	100% -
	and Deductible	No Coverage
Pain Management	20% Coinsurance	100% -
· · ··································	and Deductible	No Coverage
Approved Clinical Trials	Member Cost Sharing	100% -
• •	applicable to Routine Patient	No Coverage
	Costs outside of Approved	3
	Clinical Trial	
Cancer Drug Therapy	20% Coinsurance	100% -
0 17	and Deductible	No Coverage
Educational Services	20% Coinsurance	100% -
	and Deductible	No Coverage
		100% -
Autism Spectrum Disorder	a. \$30 Copayment; No	No Coverage
Services	Deductible	
a. Outpatient Mental	b. 20% Coinsurance and	
Health	Deductible	
b. ABA (Habilitative)		
Services		
	In Notacoule	Out of Notwork
	In-Network	Out-of-Network
	Member Financial	Member Financial
Pharmacy	Responsibility	Responsibility
Tier 1	\$15 Copayment	100% -
	No Deductible	No Coverage
Tier 2	\$50 Copayment	100% -
	No Deductible	No Coverage
Tier 3	\$100 Copayment	100% -
	No Deductible	No Coverage
Specialty Drugs	40% Coinsurance and	100% -
	Pharmacy Deductible	No Coverage
Preventive	\$0	100% -
		No Coverage