MCLAREN HEALTH PLAN COMMUNITY

HMO STANDARD PLAN – SILVER (Limited Cost Sharing)

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 \$7,000 Family	\$7,350 Individual \$14,700 Family			
Pharmacy Deductible				
\$500 Individual \$1,000 Family				
Medical	In-Network Member Financial	In-Network I/T/U Provider Member Financial	Out-of- Network I/T/U Provider Member Financial	Out-of- Network Provider Member Financial
Service	Responsibility	Responsibility	Responsibility	Responsibility
Preventive Services	\$0	\$ 0	Provider Balance Billing	100% - No Coverage
Diabetic Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$30 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit	\$65 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – 20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage

Injectable Drugs	20% Coinsurance and	\$0	Provider Balance	100% -
Provided in the Physician Office	Deductible		Billing	No Coverage
Spinal Treatment	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$75 Copayment No Deductible	\$0	Provider Balance Billing	\$75 Copayment plus Balance Billing No Deductible
Ambulance	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing No Deductible
Inpatient Hospital Service	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Home Care Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Hospice Care	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	\$30 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage

Leasting Mandal	200/ 0-1	CO	Dunidan Dalama	4000/
Inpatient Mental	20% Coinsurance	\$0	Provider Balance	100% -
Health Services	and Deductible	•	Billing	No Coverage
Emergency Mental	20% Coinsurance	\$0	Provider Balance	20% Coinsurance
Health Services	and Deductible		Billing	and Deductible
				plus Balance
				Billing
Outpatient	\$30 Copayment	\$0	Provider Balance	100% -
Substance Abuse	No Deductible		Billing	No Coverage
Services				
Inpatient Substance	20% Coinsurance	\$0	Provider Balance	100% -
Abuse Services	and Deductible		Billing	No Coverage
Emergency	20% Coinsurance	\$0	Provider Balance	20% Coinsurance
Substance Abuse	and Deductible	7 -	Billing	and Deductible
Services	and Boddonsio		29	plus Balance
				Billing
Outpatient	20% Coinsurance	\$0	Provider Balance	100% -
Habilitative Services	and Deductible	ΨΟ	Billing	No Coverage
Outpatient	20% Coinsurance	\$0	Provider Balance	100% -
Rehabilitation	and Deductible	φυ		
		# O	Billing	No Coverage
Durable Medical	20% Coinsurance	\$0	Provider Balance	100% -
Equipment (DME)	and Deductible		Billing	No Coverage
and Supplies				(222)
Reproductive Care	20% Coinsurance	\$0	Provider Balance	100% -
and Family Planning	and Deductible		Billing	No Coverage
Services				
Pediatric Vision	20% Coinsurance	\$0	Provider Balance	100% -
	and Deductible		Billing	No Coverage
Oral Surgery	20% Coinsurance	\$0	Provider Balance	100% -
	and Deductible		Billing	No Coverage
Temporomandibular	20% Coinsurance	\$0	Provider Balance	100% -
Joint Syndrome	and Deductible		Billing	No Coverage
(TMJ) Services				
Orthognathic	20% Coinsurance	\$0	Provider Balance	100% -
Surgery	and Deductible	·	Billing	No Coverage
Pain Management	20% Coinsurance	\$0	Provider Balance	100% -
	and Deductible	4.5	Billing	No Coverage
Approved Clinical	Member Cost Sharing	\$0 for Member	Provider Balance	100% -
Trials	applicable to Routine	Cost Sharing	Billing	No Coverage
Titals	Patient Costs outside	applicable to	Dilling	140 Coverage
	of Approved Clinical	Routine Patient		
	Trial	Costs outside of		
	IIIai	Approved Clinical		
Concor Dava	200/ Cainarrana	Trial	Drovidor Doloros	1000/
Cancer Drug	20% Coinsurance	\$0	Provider Balance	100% -
Therapy	and Deductible		Billing	No Coverage

Educational	20% Coinsurance	\$0	Provider Balance	100%
Services	and Deductible		Billing	No Coverage
Autism Spectrum		\$0	Provider Balance	100% -
Disorder Services			Billing	No Coverage
a. Outpatient	a. \$30 Copayment;		_	
Mental Health	No Deductible			
b. ABA	b. 20% Coinsurance			
(Habilitative)	and Deductible			
Services				
			Out-of-	
		In-Network	Network I/T/U	Out-of-
	la Natarania			
	In-Network	I/T/U Provider	Provider	Network
	Member	Member	Member	Member
	Financial	Financial	Financial	Financial
Pharmacy	Responsibility	Responsibility	Responsibility	Responsibility
Tier 1	\$15 Copayment	\$0	Provider Balance	100% -
	No Deductible		Billing	No Coverage
Tier 2	\$50 Copayment	\$0	Provider Balance	100% -
	No Deductible		Billing	No Coverage
Tier 3	\$100 Copayment	\$0	Provider Balance	100% -
	No Deductible		Billing	No Coverage
Specialty Drugs	40% Coinsurance and	\$0	Provider Balance	100% -
	Pharmacy Deductible		Billing	No Coverage
Preventive	\$0	\$0	Provider Balance	100% -
			Billing	No Coverage