MCLAREN HEALTH PLAN COMMUNITY

MCLAREN HMO STANDARD PLAN – SILVER – 0 COST SHARING/NATIVE AMERICAN

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.

| | Out of Pocket | | |
|-------------------------|---|--|--------------------------|
| Deductible | Maximum | | |
| \$0 Individual | \$0 Individual | | |
| \$0 Family | \$0 Family | | |
| Pharmacy | | | |
| Deductible | | | |
| \$0 Individual | | | |
| \$0 Family | | | |
| | In-Network Member | Out-of- Network I/T/U Provider Member | Out-of-Network Member |
| Medical | Financial | Financial | Financial |
| Service | Responsibility | Responsibility | Responsibility |
| Preventive Services | \$0 | Provider Balance | 100% - |
| | 1 | Billing | No Coverage |
| Diabetic Services | \$0 | Provider Balance | 100% - |
| Primary Care | \$0 | Billing Provider Balance | No Coverage 100% - |
| Physician (PCP) | ΨΟ | Billing | No Coverage |
| Office Visits | | | 110 00101490 |
| Specialist Office Visit | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Immunizations (other | \$0 | Provider Balance | 100% - |
| than Preventive | | Billing | No Coverage |
| Care) Maternity Care | \$0 | Provider Balance | 100% - |
| Maternity Care | ΨΟ | Billing | No Coverage |
| Injectable Drugs | \$0 | Provider Balance | 100% - |
| Provided in the | , , , , , , , , , , , , , , , , , , , | Billing | No Coverage |
| Physician Office | | | |

| Spinal Treatment | \$0 | Provider Balance | 100% - |
|-----------------------|-----|------------------|------------------|
| ' | · | Billing | No Coverage |
| Emergency Care – | \$0 | Provider Balance | Provider Balance |
| Emergency Room | | Billing | Billing |
| Urgent Care | \$0 | Provider Balance | Provider Balance |
| | | Billing | Billing |
| Ambulance | \$0 | Provider Balance | Provider Balance |
| | | Billing | Billing |
| Inpatient Hospital | \$0 | Provider Balance | 100% - |
| Service | | Billing | No Coverage |
| Outpatient Hospital | \$0 | Provider Balance | 100% - |
| Services | · | Billing | No Coverage |
| Diagnostic and | \$0 | Provider Balance | 100% - |
| Therapeutic Services | ' | Billing | No Coverage |
| and Tests (other than | | | Ü |
| Preventive Services) | | | |
| Organ and Tissue | \$0 | Provider Balance | 100% - |
| Transplants | · | Billing | No Coverage |
| Special Surgical | \$0 | Provider Balance | 100% - |
| Procedures | · | Billing | No Coverage |
| Breast | \$0 | Provider Balance | 100% - |
| Reconstruction | ' | Billing | No Coverage |
| Following | | | 5 |
| Mastectomy | | | |
| Skilled Nursing | \$0 | Provider Balance | 100% - |
| Facility Services | | Billing | No Coverage |
| Home Care Services | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Hospice Care | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Outpatient Mental | \$0 | Provider Balance | 100% - |
| Health Services | | Billing | No Coverage |
| Inpatient Mental | \$0 | Provider Balance | 100% - |
| Health Services | | Billing | No Coverage |
| Emergency Mental | \$0 | Provider Balance | Provider Balance |
| Health Services | | Billing | Billing |
| Outpatient Substance | \$0 | Provider Balance | 100% - |
| Abuse Services | | Billing | No Coverage |
| Inpatient Substance | \$0 | Provider Balance | 100% - |
| Abuse Services | | Billing | No Coverage |
| Emergency | \$0 | Provider Balance | Provider Balance |
| Substance Abuse | | Billing | Billing |
| Services | | | |
| Outpatient | \$0 | Provider Balance | 100% - |
| Habilitative Services | | Billing | No Coverage |
| | | | |

| O. starations | CO | Dunyidan Dalamas | 1000/ |
|--------------------------|---------------------|------------------|--------------|
| Outpatient | \$0 | Provider Balance | 100% - |
| Rehabilitation | Φ0 | Billing | No Coverage |
| Durable Medical | \$0 | Provider Balance | 100% - |
| Equipment (DME) | | Billing | No Coverage |
| and Supplies | | | |
| Reproductive Care | \$0 | Provider Balance | 100% - |
| and Family Planning | | Billing | No Coverage |
| Services | | | |
| Pediatric Vision | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Oral Surgery | \$0 | Provider Balance | 100% - |
| | · | Billing | No Coverage |
| Temporomandibular | \$0 | Provider Balance | 100% - |
| Joint Syndrome | 4.5 | Billing | No Coverage |
| (TMJ) Services | | 219 | 110 00101090 |
| Orthognathic Surgery | \$0 | Provider Balance | 100% - |
| | Ψ0 | Billing | No Coverage |
| Pain Management | \$0 | Provider Balance | 100% - |
| Fair Management | ΨΟ | Billing | No Coverage |
| | | Dilling | No Coverage |
| Approved Clinical | \$0 for Member Cost | Provider Balance | 100% - |
| Approved Clinical Trials | I | | |
| ITTAIS | Sharing applicable | Billing | No Coverage |
| | to Routine Patient | | |
| | Costs outside of | | |
| | Approved Clinical | | |
| | Trial | | |
| Cancer Drug Therapy | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Educational Services | \$0 | Provider Balance | 100% - |
| | | Billing | No Coverage |
| Autism Spectrum | \$0 | Provider Balance | 100% - |
| Disorder Services | , i | Billing | No Coverage |
| a. Outpatient | | | 9. |
| Mental Health | | | |
| b. ABA | | | |
| (Habilitative) | | | |
| Services | | | |
| OGI VICES | | | |
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| Pharmacy | In-Network Member Financial Responsibility | Out-of- Network I/T/U Provider Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|-----------------|---|---|---|
| Tier 1 | \$0 | Provider Balance Billing | 100% - No Coverage |
| Tier 2 | \$0 | Provider Balance Billing | 100% - No Coverage |
| Tier 3 | \$0 | Provider Balance Billing | 100% - No Coverage |
| Specialty Drugs | \$0 | Provider Balance Billing | 100% - No Coverage |
| Preventive | \$0 | Provider Balance Billing | 100% - No Coverage |