MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO – HSA PLATINUM 1350

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	
$1,350 Self-Only $2,700 Family	$1,350 Self-Only $2,700 Family	
Medical Service	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Preventive Services	$0	100% - No Coverage
Diabetic Services	No charge after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	No charge after Deductible	100% - No Coverage
Specialist Office Visit	No charge after Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	No charge after Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits – $0 All other Maternity Care – No charge after Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	No charge after Deductible	100% - No Coverage
Emergency Care – Emergency Room	No charge after Deductible	No charge after Deductible but subject to Balance Billing
Urgent Care	No charge after Deductible	No charge after Deductible but subject to Balance Billing
Ambulance	No charge after Deductible	No charge after Deductible but subject to Balance Billing
Inpatient Hospital Service	No charge after Deductible	100% - No Coverage
Outpatient Hospital Services	No charge after Deductible	100% - No Coverage

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

Temporomandibular Joint Syndrome (TMJ) Services	No charge after Deductible	100% - No Coverage
Orthognathic Surgery	No charge after Deductible	100% - No Coverage
Pain Management	No charge after 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	No charge after Deductible	100% - No Coverage
Educational Services	No charge after Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. No charge after Deductible b. No charge after Deductible	100% - No Coverage
Pharmacy	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Tier 1 (Preferred Generic)	No charge after Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	No charge after Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	No charge after Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	No charge after Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage