MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO - PLATINUM 750

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	
$750 Individual $1,500 Family	$1,500 Individual $3,000 Family	
Medical Service	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Preventive Services	$0	100% - No Coverage
Diabetic Services	10% Coinsurance and Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$25 Copayment No Deductible	100% - No Coverage
Specialist Office Visit	$50 Copayment No Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	10% Coinsurance and Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits - $0 All other Maternity Care - 10% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	10% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	$250 Copayment (waived if admitted to Hospital) No Deductible	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Urgent Care	$60 Copayment No Deductible	$60 Copayment plus Balance Billing No Deductible
Ambulance	10% Coinsurance and Deductible	10% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	10% Coinsurance and Deductible	100% - No Coverage

Outpatient Hospital Services	10% Coinsurance and Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	10% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	10% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	10% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	10% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	10% Coinsurance and Deductible	100% - No Coverage
Home Care Services	10% Coinsurance and Deductible	100% - No Coverage
Hospice Care	10% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	$25 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	10% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	$250 Copayment (waived if admitted to Hospital) No Deductible	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Substance Abuse Services	$25 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	10% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	$250 Copayment (waived if admitted to Hospital) No Deductible	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Habilitative Services	10% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation	10% Coinsurance and Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	10% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	10% Coinsurance and Deductible	100% - No Coverage

Pediatric Vision	10% Coinsurance and Deductible	100% - No Coverage
Oral Surgery	10% Coinsurance and Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	10% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	10% Coinsurance and Deductible	100% - No Coverage
Pain Management	10% Coinsurance and 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	10% Coinsurance and Deductible	100% - No Coverage
Educational Services	10% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. $25 Copayment; No Deductible b. 10% Coinsurance and Deductible	100% - No Coverage
Pharmacy	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility**
Tier 1 (Preferred Generic)	$5 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$30 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	$200 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	$300 Copayment No Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage