MCLAREN HEALTH PLAN COMMUNITY

HMO INDIVIDUAL - SILVER EXCHANGE 94% (CSR)

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	
\$250 Individual	\$1,250 Individual	
\$500 Family	\$2,500 Family	
Pharmacy Deductible		
\$0 Individual		
\$0 Family		
	In-Network Member	Out-of-Network
Medical	Financial	Member Financial
Service	Responsibility	Responsibility
Preventive Services	\$0	100% -
		No Coverage
Diabetic Services	5% Coinsurance	100% -
	and Deductible	No Coverage
Primary Care Physician	\$5 Copayment	100% -
(PCP) Office Visits	No Deductible	No Coverage
Specialist Office Visit	\$10 Copayment	100% -
	No Deductible	No Coverage
Immunizations (other than	5% Coinsurance	100% -
Preventive Care)	and Deductible	No Coverage
Maternity Care	Prenatal Office	100% -
	Visits – \$0	No Coverage
	All other Maternity Care – 5%	
	Coinsurance and Deductible	
Injectable Drugs Provided	5% Coinsurance	100% -
in the Physician Office	and Deductible	No Coverage
Emergency Care –	5% Coinsurance	5% Coinsurance
Emergency Room	and Deductible	and Deductible plus
	007.0	Balance Billing
Urgent Care	\$25 Copayment	\$25 Copayment plus
	No Deductible	Balance Billing
	50/ 0	No Deductible
Ambulance	5% Coinsurance	5% Coinsurance
	and Deductible	and Deductible

Inpatient Hospital Service	5% Coinsurance	100% -
Inpation Hoopital Colvido	and Deductible	No Coverage
Outpatient Hospital	5% Coinsurance	100% -
Services	and Deductible	No Coverage
Diagnostic and Therapeutic	5% Coinsurance	100% -
Services and Tests (other	and Deductible	No Coverage
than Preventive Services)	and Deductible	ino coverage
	5% Coinsurance	100% -
Organ and Tissue		
Transplants	and Deductible	No Coverage
Special Surgical	5% Coinsurance	100% -
Procedures	and Deductible	No Coverage
Breast Reconstruction	5% Coinsurance	100% -
Following Mastectomy	and Deductible	No Coverage
Skilled Nursing Facility	5% Coinsurance	100% -
Services	and Deductible	No Coverage
Home Care Services	5% Coinsurance	100% -
	and Deductible	No Coverage
Hospice Care	5% Coinsurance	100% -
	and Deductible	No Coverage
Outpatient Mental Health	\$5 Copayment	100% -
Services	No Deductible	No Coverage
Inpatient Mental Health	5% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Mental Health	5% Coinsurance	5% Coinsurance
Services	and Deductible	and Deductible plus
		Balance Billing
Outpatient Substance	\$5 Copayment	100% -
Abuse Services	No Deductible	No Coverage
Inpatient Substance Abuse	5% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Substance	5% Coinsurance	5% Coinsurance
Abuse Services	and Deductible	and Deductible plus
7 12 430 331 11303		Balance Billing
Outpatient Habilitative	5% Coinsurance	100% -
Services	and Deductible	No Coverage
Outpatient Rehabilitation	5% Coinsurance	100% -
2 stpation (Nonabilitation	and Deductible	No Coverage
Durable Medical Equipment	5% Coinsurance	100% -
(DME)	and Deductible	No Coverage
And Supplies	and Deductible	No Coverage
Reproductive Care and	5% Coinsurance	100% -
<u> </u>		
Family Planning Services	and Deductible	No Coverage
Pediatric Vision	5% Coinsurance	100% -
0.10	and Deductible	No Coverage
Oral Surgery	5% Coinsurance	100% -
	and Deductible	No Coverage

Temporomandibular Joint	5% Coinsurance	100% -
Syndrome (TMJ) Services	and Deductible	No Coverage
Orthognathic Surgery	5% Coinsurance	100% -
	and Deductible	No Coverage
Pain Management	5% Coinsurance	100% -
_	and Deductible	No Coverage
Approved Clinical Trials	Member Cost Sharing	100% -
	applicable to Routine Patient	No Coverage
	Costs outside of Approved	
O D Tl	Clinical Trial	1000/
Cancer Drug Therapy	5% Coinsurance	100% -
Educational Comisso	and Deductible	No Coverage
Educational Services	5% Coinsurance and Deductible	100% -
	and Deductible	No Coverage 100% -
Autism Spectrum Disorder	a. \$5 Copayment; No	No Coverage
Services	Deductible	140 Coverage
a. Outpatient Mental	b. 5% Coinsurance and	
Health	Deductible	
b. ABA (Habilitative)	Deddelible	
Services		
00111000		
	In-Network	Out-of-Network
	Member Financial	Member Financial
Pharmacy	Responsibility	Responsibility
Tier 1 (Preferred Generic)	\$3 Copayment	100% -
Tier i (Freiened Genenc)	No Deductible	No Coverage
Tier 2 (Preferred Brand)	\$5 Copayment	100% -
Tiel 2 (Freiened Bland)	No Deductible	No Coverage
Tier 3 (Non-Preferred	\$10 Copayment	100% -
Generic and Non-Preferred	No Deductible	No Coverage
Brand)	110 Doddollolo	110 Coverage
Tier 4 (Specialty Drugs)	25% Coinsurance	100% -
(2)	and Pharmacy Deductible	No Coverage
Preventive		
1 10 10 11 11 10	\$0	100% -
1 Tovollavo	\$0	No Coverage