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

Inpatient Hospital Service	5% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital Services	5% Coinsurance and Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	5% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	5% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	5% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	5% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	5% Coinsurance and Deductible	100% - No Coverage
Home Care Services	5% Coinsurance and Deductible	100% - No Coverage
Hospice Care	5% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	$5 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	5% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	5% Coinsurance and Deductible	5% Coinsurance and Deductible plus Balance Billing
Outpatient Substance Abuse Services	$5 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	5% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	5% Coinsurance and Deductible	5% Coinsurance and Deductible plus Balance Billing
Outpatient Habilitative Services	5% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation	5% Coinsurance and Deductible	100% - No Coverage
Durable Medical Equipment (DME) And Supplies	5% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	5% Coinsurance and Deductible	100% - No Coverage
Pediatric Vision	5% Coinsurance and Deductible	100% - No Coverage
Oral Surgery	5% Coinsurance and Deductible	100% - No Coverage

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