## MCLAREN HEALTH PLAN COMMUNITY

## **SMALL GROUP HMO - PLATINUM**

## 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 Individual	
\$1,500 Family	\$3,000 Family	
		Out-of-Network
Medical	In-Network Member	Member Financial
Service	Financial Responsibility	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
Spinal Treatment	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

Investigat Heggital	400/ Cairayyranaa and	4000/ No Coversor
Inpatient Hospital Service	10% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital	10% Coinsurance and	100% - No Coverage
Services	Deductible	100 % - No Coverage
Diagnostic and	10% Coinsurance and	100% - No Coverage
Therapeutic Services	Deductible	3
and Tests (other than		
Preventive Services)		
Organ and Tissue	10% Coinsurance and	100% - No Coverage
Transplants	Deductible	
Special Surgical	10% Coinsurance and	100% - No Coverage
Procedures	Deductible	
Breast Reconstruction	10% Coinsurance and	100% - No Coverage
Following Mastectomy	Deductible	
Skilled Nursing Facility	10% Coinsurance and	100% - No Coverage
Services	Deductible	
Home Care Services	10% Coinsurance and	100% - No Coverage
Harris Oraș	Deductible	4000/ NI O
Hospice Care	10% Coinsurance and	100% - No Coverage
Outpotiont Montal	Deductible	4000/ No Coversor
Outpatient Mental	\$25 Copayment	100% - No Coverage
Health Services	No Deductible 10% Coinsurance and	100% No Coverage
Inpatient Mental Health Services	Deductible	100% - No Coverage
Emergency Mental	\$250 Copayment (waived if	\$250 Copayment
Health Services	admitted to Hospital)	(waived if admitted to
Tream Corviese	No Deductible	Hospital) plus Balance
		Billing
		No Deductible
Outpatient Substance	\$25 Copayment	100% - No Coverage
Abuse Services	No Deductible	
Inpatient Substance	10% Coinsurance and	100% - No Coverage
Abuse Services	Deductible	
Emergency Substance	\$250 Copayment (waived if	\$250 Copayment
Abuse Services	admitted to Hospital)	(waived if admitted to
	No Deductible	Hospital) plus Balance
		Billing
Outration (11) 125 c	400/ Oaina	No Deductible
Outpatient Habilitative	10% Coinsurance and	100% - No Coverage
Services	Deductible	100% No Coverses
Outpatient Rehabilitation	10% Coinsurance and Deductible	100% - No Coverage
Durable Medical	10% Coinsurance and	100% - No Coverage
Equipment (DME) and	Deductible	100 % - No Coverage
Supplies	Deddelible	
Сарріїсь		

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
	Member Financial	
Pharmacy	Responsibility	Out-of-Network
Tier 1	\$5 Copayment No Deductible	100% - No Coverage
Tier 2	\$30 Copayment No Deductible	100% - No Coverage
Tier 3	\$200 Copayment No Deductible	100% - No Coverage
Specialty Drugs	\$300 Copayment No Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage