## MCLAREN HEALTH PLAN COMMUNITY

## **HMO STANDARD PLAN – GOLD (Limited Cost Sharing)**

## 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			
\$1,400 Individual \$2,800 Family	\$5,000 Individual \$10,000 Family			
Pharmacy Deductible				
\$0 Individual \$0 Family				
Medical	In-Network Member Financial	In-Network I/T/U Provider Member Financial	Out-of- Network I/T/U Provider Member Financial	Out-of- Network Member Financial
Service	Responsibility	Responsibility	Responsibility	Responsibility
Preventive Services	\$0	\$0	Provider Balance Billing	100% - No Coverage
Diabetic Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$20 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit	\$50 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – 20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage

Injectable Drugs Provided in the Physician Office	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Spinal Treatment	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$60 Copayment No Deductible	\$0	Provider Balance Billing	\$60 Copayment plus Balance Billing
Ambulance	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Home Care Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Hospice Care	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage

Emergency Mental	20% Coinsurance	\$0	Provider Balance	20% Coinsurance
Health Services	and Deductible	<b>4</b> 5	Billing	and Deductible
				plus Balance
				Billing
Outpatient	\$20 Copayment	\$0	Provider Balance	100% -
Substance Abuse	No Deductible		Billing	No Coverage
Services				
Inpatient Substance	20% Coinsurance	\$0	Provider Balance	100% -
Abuse Services	and Deductible		Billing	No Coverage
Emergency	20% Coinsurance	\$0	Provider Balance	20% Coinsurance
Substance Abuse	and Deductible		Billing	and Deductible
Services				plus Balance
0 1 1: 1	000/ 0 :	Φ0	D :1 D 1	Billing
Outpatient	20% Coinsurance	\$0	Provider Balance	100% -
Habilitative Services	and Deductible	Φ0	Billing	No Coverage
Outpatient	20% Coinsurance	\$0	Provider Balance	100% -
Rehabilitation	and Deductible	Φ0	Billing	No Coverage
Durable Medical	20% Coinsurance	\$0	Provider Balance	100% -
Equipment (DME)	and Deductible		Billing	No Coverage
and Supplies	200/ Cainavinana	<b>C</b> O	Duay dan Dalamaa	4000/
Reproductive Care	20% Coinsurance	\$0	Provider Balance	100% -
and Family Planning Services	and Deductible		Billing	No Coverage
Pediatric Vision	20% Coinsurance	\$0	Provider Balance	100% -
rediatife vision	and Deductible	φυ	Billing	No Coverage
Oral Surgery	20% Coinsurance	\$0	Provider Balance	100% -
Oral Surgery	and Deductible	ΨΟ	Billing	No Coverage
Temporomandibular	20% Coinsurance	\$0	Provider Balance	100% -
Joint Syndrome	and Deductible	Ψ σ	Billing	No Coverage
(TMJ) Services	5			
Orthognathic	20% Coinsurance	\$0	Provider Balance	100% -
Surgery	and Deductible	·	Billing	No Coverage
Pain Management	20% Coinsurance	\$0	Provider Balance	100% -
	and Deductible		Billing	No Coverage
Approved Clinical	Member Cost	\$0 for Member	Provider Balance	100% -
Trials	Sharing applicable	Cost Sharing	Billing	No Coverage
	to Routine Patient	applicable to		
	Costs outside of	Routine Patient		
	Approved Clinical	Costs outside of		
	Trial	Approved Clinical		
	000/ 0 :	Trial		40007
Cancer Drug	20% Coinsurance	\$0	Provider Balance	100% -
Therapy	and Deductible	Φ0	Billing	No Coverage
Educational	20% Coinsurance	\$0	Provider Balance	100% -
Services	and Deductible		Billing	No Coverage

Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. \$20 Copayment; No Deductible b. 20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
	In-Network Member Financial	In-Network I/T/U Provider Member Financial	Out-of- Network I/T/U Provider Member Financial	Out-of- Network Member Financial
Pharmacy	Responsibility	Responsibility	Responsibility	Responsibility
Tier 1	\$10 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Tier 2	\$40 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Tier 3	\$75 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Specialty Drugs	30% Coinsurance and Pharmacy Deductible	\$0	Provider Balance Billing	100% - No Coverage
Preventive Drugs	\$0	\$0	Provider Balance Billing	100% - No Coverage