## MCLAREN HEALTH PLAN COMMUNITY

## **HMO - SILVER**

## 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	
\$4,000 Individual	\$7,350 Individual	
\$8,000 Family	\$14,700 Family	
-	In-Network Member	Out-of-Network
Medical	Financial	Member Financial
Service	Responsibility	Responsibility
Preventive Services	\$0	100% -
		No Coverage
Diabetic Services	30% Coinsurance	100% -
	and Deductible	No Coverage
Primary Care Physician	\$40 Copayment	100% -
(PCP) Office Visits	No Deductible	No Coverage
Specialist Office Visit	\$80 Copayment	100% -
	No Deductible	No Coverage
Immunizations (other than	30% Coinsurance	100% -
Preventive Care)	and Deductible	No Coverage
Maternity Care	Prenatal Office	100% -
	Visits – \$0	No Coverage
	All other Maternity Care –	
	30% Coinsurance and	
	Deductible	
Injectable Drugs Provided	30% Coinsurance	100% -
in the Physician Office	and Deductible	No Coverage
Spinal Treatment	30% Coinsurance	100% -
	and Deductible	No Coverage
Emergency Care –	\$400 Copayment (waived if	\$400 Copayment (waived
Emergency Room	admitted to Hospital)	if admitted to Hospital)
	No Deductible	plus Balance Billing
		No Deductible
Urgent Care	\$60 Copayment	\$60 Copayment plus
	No Deductible	Balance Billing
		No Deductible
Ambulance	30% Coinsurance	30% Coinsurance and
	and Deductible	Deductible plus Balance
		Billing

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Inpatient Hospital Service	30% Coinsurance	100% -
0 (10) (10)	and Deductible	No Coverage
Outpatient Hospital	30% Coinsurance	100% -
Services	and Deductible	No Coverage
Diagnostic and Therapeutic	30% Coinsurance	100% -
Services and Tests (other	and Deductible	No Coverage
than Preventive Services)	200/ 2	1000/
Organ and Tissue	30% Coinsurance	100% -
Transplants	and Deductible	No Coverage
Special Surgical	30% Coinsurance	100% -
Procedures	and Deductible	No Coverage
Breast Reconstruction	30% Coinsurance	100% -
Following Mastectomy	and Deductible	No Coverage
Skilled Nursing Facility	30% Coinsurance	100% -
Services	and Deductible	No Coverage
Home Care Services	30% Coinsurance	100% -
	and Deductible	No Coverage
Hospice Care	30% Coinsurance	100% -
	and Deductible	No Coverage
Outpatient Mental Health	\$40 Copayment	100% -
Services	No Deductible	No Coverage
Inpatient Mental Health	30% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Mental Health	\$400 Copayment (waived if	\$400 Copayment (waived
Services	admitted to Hospital)	if admitted to Hospital)
	No Deductible	plus Balance Billing
		No Deductible
Outpatient Substance	\$40 Copayment	100% -
Abuse Services	No Deductible	No Coverage
Inpatient Substance Abuse	30% Coinsurance	100% -
Services	and Deductible	No Coverage
Emergency Substance	\$400 Copayment (waived if	\$400 Copayment (waived
Abuse Services	admitted to Hospital)	if admitted to Hospital)
	No Deductible	plus Balance Billing
		No Deductible
Outpatient Habilitative	30% Coinsurance	100% -
Services	and Deductible	No Coverage
Outpatient Rehabilitation	30% Coinsurance	100% -
	and Deductible	No Coverage
Durable Medical Equipment	30% Coinsurance	100% -
(DME)	and Deductible	No Coverage
And Supplies		
Reproductive Care and	30% Coinsurance	100% -
Family Planning Services	and Deductible	No Coverage
Pediatric Vision	30% Coinsurance	100% -
	and Deductible	No Coverage
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Oral Surgery	30% Coinsurance	100% -
l Star Sargery	and Deductible	No Coverage
Temporomandibular Joint	30% Coinsurance	100% -
Syndrome (TMJ) Services	and Deductible	No Coverage
Orthognathic Surgery	30% Coinsurance	100% -
	and Deductible	No Coverage
Pain Management	30% Coinsurance	100% -
	and Deductible	No Coverage
Approved Clinical Trials	Member Cost Sharing	100% -
	applicable to Routine Patient	No Coverage
	Costs outside of Approved	3
	Clinical Trial	
Cancer Drug Therapy	30% Coinsurance	100% -
	and Deductible	No Coverage
Educational Services	30% Coinsurance	100% -
	and Deductible	No Coverage
		100% -
Autism Spectrum Disorder	a. \$40 Copayment; No	No Coverage
Services	Deductible	
a. Outpatient Mental	b. 30% Coinsurance and	
Health	Deductible	
b. ABA (Habilitative)		
Services		
	In-Network	Out-of-Network
	Member Financial	Member Financial
Pharmacy	Responsibility	Responsibility
Tier 1	\$20 Copayment	100% -
	No Deductible	No Coverage
Tier 2	\$60 Copayment	100% -
	No Deductible	No Coverage
Tier 3	\$200 Copayment	100% -
	No Deductible	No Coverage
Specialty Drugs	\$300 Copayment	100% -
	No Deductible	No Coverage
Preventive	\$0	100% -
		No Coverage