# MCLAREN HEALTH PLAN COMMUNITY

## HMO STANDARD PLAN – SILVER (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** | | | |
|---|---|---|---|---|
| $3,500 Individual<br>$7,000 Family | $7,350 Individual<br>$14,700 Family | | | |
| **Pharmacy Deductible** | | | | |
| $500 Individual<br>$1,000 Family | | | | |
| **Medical Service** | **In-Network Member Financial Responsibility** | **In-Network I/T/U Provider Member Financial Responsibility** | **Out-of-Network I/T/U Provider Member Financial Responsibility** | **Out-of-Network Provider Member Financial 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 | $30 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Specialist Office Visit | $65 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<br>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 | $75 Copayment No Deductible | $0 | Provider Balance Billing | $75 Copayment plus Balance Billing No Deductible |
| Ambulance | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 20% Coinsurance and Deductible plus Balance Billing No Deductible |
| 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 | $30 Copayment No 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 Health Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 20% Coinsurance and Deductible plus Balance Billing |
| Outpatient Substance Abuse Services | $30 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Inpatient Substance Abuse Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Substance Abuse Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 20% Coinsurance and Deductible plus Balance Billing |
| Outpatient Habilitative Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Rehabilitation | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Durable Medical Equipment (DME) and Supplies | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Reproductive Care and Family Planning Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Pediatric Vision | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Oral Surgery | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Temporomandibular Joint Syndrome (TMJ) Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Orthognathic Surgery | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Pain Management | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Approved Clinical Trials | Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | $0 for Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | Provider Balance Billing | 100% - No Coverage |
| Cancer Drug Therapy | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |

| | | | | |
|---|---|---|---|---|
| Educational Services | 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% No Coverage |
| Autism Spectrum Disorder Services<br>a. Outpatient Mental Health<br>b. ABA (Habilitative) Services | a. $30 Copayment; No Deductible<br>b. 20% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| **Pharmacy** | **In-Network Member Financial Responsibility** | **In-Network I/T/U Provider Member Financial Responsibility** | **Out-of-Network I/T/U Provider Member Financial Responsibility** | **Out-of-Network Member Financial Responsibility** |
| Tier 1 | $15 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 2 | $50 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 3 | $100 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Specialty Drugs | 40% Coinsurance and Pharmacy Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Preventive | $0 | $0 | Provider Balance Billing | 100% - No Coverage |