MCLAREN HEALTH PLAN COMMUNITY
POINT OF SERVICE

STATE OF MICHIGAN – N072– PLAN YEAR 2023

SCHEDULE OF MEMBER COST SHARING AND ADDITIONAL LIMITS OF COVERAGE

This document is a part of your Certificate of Coverage and shows costs for which Members are responsible, including Copayments, Coinsurance and Deductibles, and also additional limits of Coverage.

Option A **Deductible:** **$125 - Individual** **$250 - Family** **Out of Pocket Max:** **$2,000 - Individual** **$4,000 - Family**	**Option B** **Deductible:** **$250 - Individual** **$500 - Family** **Out of Pocket Max:** **$2,000 - Individual** **$4,000 - Family**

Medical Service	**Option A Member Financial Responsibility**	**Option B Member Financial Responsibility**
Preventive Services (other than Preventive Immunizations)	$0	30% Coinsurance after Deductible plus Balance Billing
Preventive Immunizations	$0	Not Covered
Primary Care Physician (PCP) Office Visits	$20 Copayment No Deductible	30% Coinsurance after Deductible Plus Balance Billing
Specialist Office Visit (other than Allergy Test, Serum and Injections)	$20 Copayment No Deductible	30% Coinsurance after Deductible Plus Balance Billing
Allergy testing and therapy (non-injection	$0 after Deductible	30% Coinsurance after Deductible Plus Balance Billing
Allergy Injections	$0	30% Coinsurance after Deductible Plus Balance Billing
Immunizations (other than Preventive Care)	$0	Not Covered
Maternity Care – Prenatal Visits	$0	30% Coinsurance after Deductible Plus Balance Billing

Medical Service	Option A Member Financial Responsibility	Option B Member Financial Responsibility
Maternity Care – Postnatal	$20 Copayment	30% Coinsurance after Deductible Plus Balance Billing
Injectable Drugs Provided in the Physician Office	$0	30% Coinsurance after Deductible Plus Balance Billing
Spinal Treatment	$20 Copayment after Deductible Limited to 24 visits per Plan Year	Not Covered
Emergency Care – Emergency Room	$200 (waived if admitted to Hospital) No Deductible	$200 (waived if admitted to Hospital) No Deductible
Urgent Care	$20 Copayment No Deductible	$20 Copayment Plus Balance Billing No Deductible
Ground Ambulance	$0 after Deductible	$0 after Deductible Plus Balance Billing
Air Ambulance	$0 after Deductible	$0 after Deductible
Inpatient Hospital Service	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Outpatient Hospital Services	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Laboratory and Pathology	$0	30% Coinsurance after Deductible Plus Balance Billing
Diagnostic and Therapeutic Services and Tests and X-rays (other than Preventive Services)	$0 after Deductible	30% Coinsurance after Deductible Plus Balance Billing
Organ and Tissue Transplants	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Special Surgical Procedures – Surgical Fees	$0 after Deductible	Not Covered
Breast Reconstruction Following Mastectomy	$0 after Deductible	Not Covered
Skilled Nursing Facility Services	$0 after Deductible Limited to 120 days per Plan Year	Not Covered

Medical Service	Option A Member Financial Responsibility	Option B Member Financial Responsibility
Home Care Services	$20 Copayment after Deductible	Not Covered
Private Duty Nursing	$0	Not Covered
Hospice Care	$0 after Deductible	Not Covered
Outpatient Mental Health Services	$20 Copayment No Deductible	30% Coinsurance after Deductible Plus Balance Billing
Inpatient Mental Health Services	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Emergency Mental Health Services	$200 (waived if admitted to Hospital) No Deductible	$200 (waived if admitted to Hospital) No Deductible
Outpatient Substance Abuse Services	$20 Copayment No Deductible	30% Coinsurance after Deductible Plus Balance Billing
Inpatient Substance Abuse Services	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Emergency Substance Abuse Services	$200 (waived if admitted to Hospital) No Deductible	$200 (waived if admitted to Hospital) No Deductible
Outpatient Habilitative Services – ABA Treatment for Autism	$0 after Deductible	Not Covered
Outpatient Habilitative – Other than ABA Treatment	$20 Copayment Combined maximum benefit – 90 visits/Plan year	20% Coinsurance after Deductible Plus Balance Billing Combined maximum benefit – 90 visits/Plan year
Outpatient Rehabilitation	$20 Copayment Combined maximum benefit – 90 visits/Plan year	20% Coinsurance after Deductible Plus Balance Billing Combined maximum benefit – 90 visits/Plan year
Durable Medical Equipment (DME)	$0	Not Covered
Prosthetics, Orthotics and Corrective Appliances	$0	Not Covered
Infertility Treatment counseling	$0 after Deductible	Not Covered

Medical Service	Option A Member Financial Responsibility	Option B Member Financial Responsibility
Female Sterilization	$0 (Covered under Preventive Services)	Not Covered
Male Vasectomy	$0 after Deductible	Not Covered
Elective Termination of Pregnancy	$0	Not Covered
Reproductive Care and Family Planning	$20 Copayment/Office Visit	Not Covered
Genetic Testing	$20 Copayment/Office Visit	Not Covered
Oral Surgery	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Temporomandibular Joint Syndrome (TMJ) Services	$0 after Deductible Deductible	20% Coinsurance after Deductible Plus Balance Billing
Orthognathic Surgery	$0 after Deductible	20% Coinsurance after Deductible Plus Balance Billing
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial
Cancer Drug Therapy	$0 after Deductible	20% Coinsurance and Deductible Plus Balance Billing
Vision Exam	$20 Copayment	30% Coinsurance after Deductible Plus Balance Billing
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. $20 Copayment – No Deductible b. $0 after Deductible	a. 30% Coinsurance after Deductible Plus Balance Billing b. Not Covered
Hearing Aid	$0	Not Covered
Virtual Visit	$0	Not Covered

Pharmacy	Retail	Mail Order
Tier 1	$10 Copayment No Deductible	$20 Copayment No Deductible
Tier 2	$30 Copayment No Deductible	$60 Copayment No Deductible
Tier 3	$60 Copayment No Deductible	$120 Copayment No Deductible
Specialty Drugs	$60 Copayment No Deductible * Must be filled at a Participating Specialty Pharmacy.	Not Covered