MCLAREN HEALTH ADVANTAGE

PREMIER – 2023

SCHEDULE OF MEMBER COST SHARING

This document is part of your McLaren Health Advantage Medical Benefits document. It provides detailed information about member out-of-pocket expenses and certain limitations of coverage. It does not include all conditions of coverage; refer to your Health Benefits booklet for additional terms of coverage, especially preauthorization requirements.

	In-Network Providers (Domestic Network and MHA Network)	**Out-of-Network** **Secondary Network** **All other Hospitals and Physicians**
Annual Deductible	$500 Individual $1,000 Family	$2,000 Individual $4,000 Family
Medical and Pharmacy Copayment Out-of-Pocket Maximum	$7,600 Individual $15,200 Family	$8, 000 Individual $16,000 Family
Medical Coinsurance Out-of-Pocket Maximum	$1,000 Individual $2,000 Family	$5,000 Individual $10,000 family
Total Medical Out-of-Pocket Maximum	$9,100 Individual $18,200 Family	$15,000 Individual $30,000 Family

MEDICAL SERVICES				
Medical Service	**In Network Providers (Domestic network and MHA Network)** **Member Financial Responsibility**	**Out-of-Network - Secondary Network (Includes Specifically-Designated Providers)** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Preventive Services	$0	100% No Coverage	100% No Coverage	
Diabetic Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Primary Care Physician (PCP) Office Visits	$25 Copayment No Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Specialist Office Visit	$40 Copayment No Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Allergy Testing and Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Immunizations (other than Preventive Care)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Maternity Care (Prenatal and Postnatal Visits, Delivery and Routine Nursery Care)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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Injectable Drugs Provided in the Physician Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Spinal Treatment	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 24 visits per Plan Year
Emergency Care – Emergency Room	$150 Copayment No Deductible	$150 Copayment No Deductible	$150 Copayment No Deductible	
Urgent Care	$50 Copayment No Deductible	$50 Copayment No Deductible	$50 Copayment Plus Balance Bill	
Ambulance	100%	100%	Provider Balance Bill*	*Surprise billing rules prohibiting balance billing may apply for certain air ambulance services
Inpatient and Long Term Acute Hospital Services (including Consultations by a Physician)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Outpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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Diagnostic and Therapeutic Services and Tests (e.g., therapeutic radiology, diagnostic radiology, diagnostic laboratory and pathology services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	For laboratory services, only Domestic and Preferred Laboratory Providers[1] are considered In-Network. All other laboratories are Out-of-Network with Provider Balance Bill.
Organ and Tissue Transplants	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Special Surgical Procedures	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Breast Reconstruction Following Mastectomy	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Skilled Nursing Facility Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 120 days per Plan Year
Home Care Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

[1] JVHL is the preferred laboratory provider for Michigan. For McLaren St. Luke's covered members only, the preferred laboratory providers are considered the in-network providers listed in the Ohio Provider Directory on McLaren Health Advantage's website.

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Hospice Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Outpatient Mental Health Services	$25 Copayment No Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Mental Health Services (Including Partial Treatment Programs and Residential Mental Health Treatment)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Emergency Mental Health Services	$150 Copayment No Deductible	$150 Copayment No Deductible	$150 copayment No Deductible	
Outpatient Substance Abuse Services	$25 Copayment No Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Substance Abuse Services (Including Partial Hospitalization and Residential Substance Abuse Treatment)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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Emergency Substance Abuse Services	$150 Copayment No Deductible	$150 Copayment No Deductible	$150 Copayment No Deductible	
Outpatient Habilitation Services	100% Not Covered	100% Not Covered	100% Not Covered	
Outpatient Rehabilitation (Physical, Speech and Occupational Therapy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 60 visits, per condition, per Plan Year
Durable Medical Equipment (DME) and Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if: • Purchase price is $5,000 or more • Rental is $500 or more per month
Prostheses, Orthotics and Corrective Appliances	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if purchase price is $5,000 or more
Reproductive Care and Family Planning Services (including Diagnosis of Infertility, Genetic Testing, Vasectomy and Termination of Pregnancy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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Oral Surgery, TMJ Treatment and Orthognathic Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Pain Management	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
End Stage Renal Disease (Physician and Facility Services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
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	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	
Cancer Drug Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
NICU	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

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Burn	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
High Risk OB	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	
Applied Behavior Analysis (ABA) Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible Plus Provider Balance Bill	

PHARMACY BENEFITS		
Drug	**Preferred Pharmacies** **Member Financial Responsibility**	**Non-Preferred Pharmacies** **Member Financial Responsibility**
Tier 1 (Preferred Generic)	$10 Copayment[2] No Deductible	$10 Copayment Plus 25% of Reimbursement Amount Paid by Plan
Tier 2 (Preferred Brand)	$30 Copayment[2]	$30 Copayment Plus 25% of Reimbursement Amount Paid by Plan
Tier 3 (Non-Preferred Generic, Non-Preferred Brand and Specialty Drugs)	$50 Copayment[2] No Deductible	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan
Preventive Drugs	$0[2]	25% of Reimbursement Amount Paid by Plan
Mail Order Drugs – (Preferred Generic, Non-Preferred Generic, Preferred Brand and Non-Preferred Brand Name Drugs and Preventive Drugs)	One Copayment (as applicable) for a 3-month supply[3]	

NOTE: For a complete description of benefits, further limitations, conditions and exclusions, also refer to the Health Benefits booklet. Benefits are subject to change or revision without notice, and this form is not a guarantee of past or future benefits. For McLaren Health Advantage, "Covered" out-of-network services means that the services are payable at McLaren Health Advantage's reimbursement amount, less any applicable deductible, coinsurance and/or copayment required by the Plan. If you choose to see an out-of-network provider, you may be responsible for any "balance billed" monetary difference between McLaren Health Advantage's reimbursement amount and the non-contracted, out-of-network provider's billed charges. Balance billing can occur when receiving care from a non-contracted, out-of-network provider.

[2] A 3-month supply of Tier 1, Tier 2, Tier 3 non-preferred generic and preventive drugs may be obtained through retail if a member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment for Tier 1 Drugs, and three copayments for Tier 2 and Tier 3 non-preferred generic and non-preferred brand drugs.

[3] A 3-month supply of Tier, 1, Tier 2, Tier 3 brand drugs and preventive drugs may be obtained through mail order if a member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment.