MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO – GOLD HSA 1750
SCHEDULE OF COST SHARING

This document is 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
$1,750 Self-Only $3,500 Family	$3,000 Self-Only $6,000 Family

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	$0	100% - No Coverage
Diabetic Services	20% Coinsurance and Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	20% Coinsurance and Deductible	100% - No Coverage
Specialist Office Visit	20% Coinsurance and Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	100% - No Coverage
Maternity Care	Prenatal Office Visits - $0 All other Maternity Care – 20% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	20% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Urgent Care	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Ambulance	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Services	20% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital Services	20% Coinsurance and Deductible	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	20% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	20% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	20% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance and Deductible	100% - No Coverage
Home Care Services	20% Coinsurance and Deductible	100% - No Coverage
Hospice Care	20% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	20% Coinsurance and Deductible	100% - No Coverage
Inpatient Mental Health Services	20% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Outpatient Substance Abuse Services	20% Coinsurance and Deductible	100% - No Coverage
Inpatient Substance Abuse Services	20% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	20% Coinsurance and Deductible	20% Coinsurance and Deductible plus Balance Billing
Outpatient Habilitative Services	20% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation	20% Coinsurance and Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	20% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	20% Coinsurance and Deductible	100% - No Coverage
Pediatric Vision	20% Coinsurance and Deductible	100% - No Coverage
Oral Surgery	20% Coinsurance and Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	20% Coinsurance and Deductible	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Orthognathic Surgery	20% Coinsurance and Deductible	100% - No Coverage
Pain Management	20% Coinsurance and Deductible	100% - No Coverage
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	100% - No Coverage
Cancer Drug Therapy	20% Coinsurance and Deductible	100% - No Coverage
Educational Services	20% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	 a. 20% Coinsurance and Deductible b. 20% Coinsurance and Deductible	100% - No Coverage
Vision Exam (Adult)	20% Coinsurance and Deductible	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	After Deductible - $25 Copayment	100% - No Coverage
Tier 2 (Preferred Brand)	After Deductible - $75 Copayment	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	After Deductible - $100 Copayment	100% - No Coverage
Tier 4 (Specialty Drugs)	20% Coinsurance and Deductible (After Deductible, maximum of $300 of Coinsurance per Specialty Drug fill (e.g., one 30-day supply))	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage