

MCLAREN HEALTH PLAN COMMUNITY**SMALL GROUP HMO – GOLD 1250****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 |
|--------------------------------------|---------------------------------------|
| \$1,250 Individual \$2,500 Family | \$6,500 Individual \$13,000 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 | \$30 Copayment No Deductible | 100% - No Coverage |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | \$60 Copayment No Deductible | 100% - No Coverage |
| Allergy Testing (Non-Injections) | 20% Coinsurance and Deductible | 100% - No Coverage |
| Allergy Injections | \$0 | 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 | \$250 Copayment (waived if admitted to Hospital) No Deductible | \$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible |
| Urgent Care | \$50 Copayment No Deductible | \$50 Copayment plus Balance Billing No Deductible |
| Ambulance | 20% Coinsurance and Deductible | 20% Coinsurance and Deductible plus Balance Billing |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|--|--|--|
| Inpatient Hospital Services | 20% Coinsurance and Deductible | 100% - No Coverage |
| Outpatient Hospital Services | 20% Coinsurance and Deductible | 100% - No Coverage |
| 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 | \$30 Copayment No Deductible | 100% - No Coverage |
| Inpatient Mental Health Services | 20% Coinsurance and Deductible | 100% - No Coverage |
| Emergency Mental Health Services | \$250 Copayment (waived if admitted to Hospital) No Deductible | \$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible |
| Outpatient Substance Abuse Services | \$30 Copayment No Deductible | 100% - No Coverage |
| Inpatient Substance Abuse Services | 20% Coinsurance and Deductible | 100% - No Coverage |
| Emergency Substance Abuse Services | \$250 Copayment (waived if admitted to Hospital) No Deductible | \$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible |
| 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 |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|
| 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 |
| 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 <ul style="list-style-type: none"> a. Outpatient Mental Health b. ABA (Habilitative) Services | <ul style="list-style-type: none"> a. \$30 Copayment; No 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) | \$25 Copayment No Deductible | 100% - No Coverage |
| Tier 2 (Preferred Brand) | \$50 Copayment No Deductible | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | \$125 Copayment No Deductible | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | \$275 Copayment No Deductible | 100% - No Coverage |
| Preventive Drugs | \$0 | 100% - No Coverage |