MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – GOLD 1400 – LIMITED COST SHARING SCHEDULE OF COST SHARING

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	Pharmacy Deductible
\$1,400 Individual	\$7,300 Individual	\$0 Individual
\$2,800 Family	\$14,600 Family	\$0 Family

Benefit	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
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 (other than Allergy Testing and Allergy Injections)	\$50 Copayment No Deductible	\$0	Provider Balance Billing	100% - No Coverage
Allergy Testing (Non-Injections)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Allergy Injections	\$0	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage

Benefit	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
Maternity Care	 Prenatal Office Visits - \$0 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
Emergency Care –	20% Coinsurance	\$0		20% Coinsurance
Emergency Room	and Deductible			and Deductible
Urgent Care	\$60 Copayment No Deductible	\$0	Provider Balance Billing	\$60 Copayment plus Balance Billing No Deductible
Ground Ambulance	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
Air Ambulance	20% Coinsurance and Deductible	\$0	20% Coinsurance and Deductible	20% Coinsurance and Deductible
Inpatient Hospital Services	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	20% Coinsurance	\$0	Provider	100% -
Transplants	and Deductible		Balance Billing	No Coverage

Benefit	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
Special Surgical	20% Coinsurance	\$0	Provider	100% -
Procedures	and Deductible		Balance Billing	No Coverage
Breast	20% Coinsurance	\$0	Provider	100% -
Reconstruction	and Deductible		Balance Billing	No Coverage
Following				
Mastectomy				
Skilled Nursing	20% Coinsurance	\$0	Provider	100% -
Facility Services	and Deductible		Balance Billing	No Coverage
Home Care Services	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Hospice Care	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Outpatient Mental	\$30 Copayment	\$0	Provider	100% -
Health Services	No Deductible		Balance Billing	No Coverage
Inpatient Mental	20% Coinsurance	\$0	Provider	100% -
Health Services	and Deductible		Balance Billing	No Coverage
Emergency Mental	20% Coinsurance	\$0	20% Coinsurance	20% Coinsurance
Health Services	and Deductible		and Deductible	and Deductible
Outpatient	\$30 Copayment	\$0	Provider	100% -
Substance Abuse	No Deductible		Balance Billing	No Coverage
Services				
Inpatient Substance	20% Coinsurance	\$0	Provider	100% -
Abuse Services	and Deductible		Balance Billing	No Coverage
Emergency	20% Coinsurance	\$0	20% Coinsurance	20% Coinsurance
Substance Abuse	and Deductible		and Deductible	and Deductible
Services				
Outpatient	20% Coinsurance	\$0	Provider	100% -
Habilitative Services	and Deductible		Balance Billing	No Coverage
Outpatient	20% Coinsurance	\$0	Provider	100% -
Rehabilitation	and Deductible		Balance Billing	No Coverage
Durable Medical	20% Coinsurance	\$0	Provider	100% -
Equipment (DME) and Supplies	and Deductible		Balance Billing	No Coverage
Reproductive Care	20% Coinsurance	\$0	Provider	100% -
and Family Planning	and Deductible		Balance Billing	No Coverage
Services				

Benefit	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
Pediatric Vision	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Oral Surgery	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Temporomandibular	20% Coinsurance	\$0	Provider	100% -
Joint Syndrome	and Deductible		Balance Billing	No Coverage
(TMJ) Services				
Orthognathic	20% Coinsurance	\$0	Provider	100% -
Surgery	and Deductible		Balance Billing	No Coverage
Pain Management	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Approved Clinical	Member Cost	\$0 for Member	Provider	100% -
Trials	Sharing	Cost Sharing	Balance Billing	No Coverage
	applicable to	applicable to		
	Routine Patient	Routine Patient		
	Costs outside of	Costs outside of		
	Approved Clinical	Approved Clinical		
	Trial	Trial		
Cancer Drug	20% Coinsurance	\$0	Provider	100% -
Therapy	and Deductible		Balance Billing	No Coverage
Educational Services	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Autism Spectrum		\$0	Provider	100% -
Disorder Services			Balance Billing	No Coverage
a. Outpatient	a. \$30			
Mental	Copayment;			
Health	No Deductible			
b. ABA	b. 20%			
(Habilitative)	Coinsurance			
Services	and Deductible			

Pharmacy	In-Network	In-Network	Out-of-Network	Out-of-Network
	Member	I/T/U Provider	I/T/U Provider	Member
	Financial	Member	Member	Financial
	Responsibility*	Financial	Financial	Responsibility
		Responsibility	Responsibility	

Tier 1 (Preferred	\$10 Copayment	\$0	Provider	100% -
Generic)	No Deductible		Balance Billing	No Coverage
Tier 2 (Preferred	\$60 Copayment	\$0	Provider	100% -
Brand)	No Deductible		Balance Billing	No Coverage
Tier 3 (Non-	\$100 Copayment	\$0	Provider	100% -
Preferred Generic	No Deductible		Balance Billing	No Coverage
and Non-Preferred				
Brand)				
Tier 4 (Specialty	30% Coinsurance	\$0	Provider	100% -
Drugs)	No Deductible		Balance Billing	No Coverage
Preventive Drugs	\$0	\$0	Provider	100% -
			Balance Billing	No Coverage

^{*}Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy.