MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – GOLD STANDARD

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
$2,000 Individual $4,000 Family	$8,700 Individual $17,400 Family

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	$0	100% - No Coverage
Diabetic Services	25% 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)	25% Coinsurance and Deductible	100% - No Coverage
Allergy Injections	$0	100% - No Coverage
Immunizations (other than Preventive Care)	25% Coinsurance and Deductible	100% - No Coverage
Maternity Care	• Prenatal Office Visits - $0 • All other Maternity Care - 25% Coinsurance and Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	25% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	25% Coinsurance and Deductible	25% Coinsurance and Deductible
Urgent Care	$45 Copayment No Deductible	$45 Copayment plus Balance Billing No Deductible
Ground Ambulance	25% Coinsurance and Deductible	25% Coinsurance and Deductible plus Balance Billing

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Air Ambulance	25% Coinsurance and Deductible	25% Coinsurance and Deductible
Inpatient Hospital Services	25% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital Services	25% Coinsurance and Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	25% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	25% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	25% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	25% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	25% Coinsurance and Deductible	100% - No Coverage
Home Care Services	25% Coinsurance and Deductible	100% - No Coverage
Hospice Care	25% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	$30 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	25% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	25% Coinsurance and Deductible	25% Coinsurance and Deductible
Outpatient Substance Abuse Services	$30 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	25% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	25% Coinsurance and Deductible	25% Coinsurance and Deductible
Outpatient Habilitative Services (not including Speech Therapy, Occupational Therapy, and Physical Therapy)	25% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy)	25% Coinsurance and Deductible	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Speech Therapy, Occupational Therapy, and Physical Therapy	$30 Copayment No Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	25% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	25% Coinsurance and Deductible	100% - No Coverage
Pediatric Vision	25% Coinsurance and Deductible	100% - No Coverage
Oral Surgery	25% Coinsurance and Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	25% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	25% Coinsurance and Deductible	100% - No Coverage
Pain Management	25% 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	25% Coinsurance and Deductible	100% - No Coverage
Educational Services	25% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. $30 Copayment; No Deductible b. 25% Coinsurance and Deductible	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility*	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	$15 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$30 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	$60 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	$250 Copayment No Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage

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