MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – MHP 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.

In-Network Combined Medical and Drug Deductible		Out-of-Network Combined Medical and Drug Deductible	
Individual	*Family*	*Individual*	*Family*
$2,500	$2,500 per person $5,000 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		Out-of-Network Out-of-Pocket Maximum	
Individual	*Family*	*Individual*	*Family*
$8,600	$8,600 per person $17,200 per group	Not Applicable	Not Applicable

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Preventive Services	$0	100% - No Coverage
Diabetic Services and Supplies (other than Diabetes Education)	25% Coinsurance after 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 after Deductible	100% - No Coverage
Allergy Injections	25% Coinsurance after Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	25% Coinsurance after Deductible	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	100% - No Coverage
Maternity Care – All Other Maternity Care	25% Coinsurance after Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	25% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Emergency Care – Emergency Room	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Urgent Care	$45 Copayment No Deductible	$45 Copayment No Deductible plus Balance Billing
Ground Ambulance	25% Coinsurance after Deductible	25% Coinsurance after Deductible plus Balance Billing
Air Ambulance	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible	100% - No Coverage
Outpatient Hospital Services	25% Coinsurance after Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	25% Coinsurance after Deductible	100% - No Coverage
Organ and Tissue Transplants	25% Coinsurance after Deductible	100% - No Coverage
Special Surgical Procedures	25% Coinsurance after Deductible	100% - No Coverage
Weight Loss Procedures	25% Coinsurance after Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	25% Coinsurance after Deductible	100% - No Coverage
Skilled Nursing Facility Services	25% Coinsurance after Deductible	100% - No Coverage
Home Care Services	25% Coinsurance after Deductible	100% - No Coverage
Hospice Care	25% Coinsurance after Deductible	100% - No Coverage
Outpatient Mental Health Services	$30 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	25% Coinsurance after Deductible	100% - No Coverage
Emergency Mental Health Services	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Outpatient Substance Abuse Services	$30 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	25% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Emergency Substance Abuse Services	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Outpatient Habilitative Services	$30 Copayment No Deductible	100% - No Coverage
Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy)	25% Coinsurance after Deductible	100% - No Coverage
Speech Therapy, Occupational Therapy, and Physical Therapy	$30 Copayment No Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	25% Coinsurance after Deductible	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	25% Coinsurance after Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	25% Coinsurance after Deductible	100% - No Coverage
Pediatric Vision	$0	100% - No Coverage
Oral Surgery	25% Coinsurance after Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	25% Coinsurance after Deductible	100% - No Coverage
Orthognathic Surgery	25% Coinsurance after Deductible	100% - No Coverage
Pain Management	25% Coinsurance after 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 after Deductible	100% - No Coverage
Educational and Nutritional Counseling Services	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	$30 Copayment No Deductible	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	25% Coinsurance after Deductible	100% - No Coverage
Vision Exam (Adult)	25% Coinsurance after Deductible	100% - No Coverage

*Note - except for balance billing, Cost-Sharing for Out-of-Network Covered Services applies towards the In-Network Cost-Sharing (e.g., Deductible and Out-of-Pocket Maximum, when applicable).

Pharmacy Benefit	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.