MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – GOLD STANDARD – ZERO 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.

In-Network Combined Medical and Drug Deductible		**Out-of-Network Combined Medical and Drug Deductible**	
Individual	*Family*	*Individual*	*Family*
$0	$0 per person $0 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		**Out-of-Network Out-of-Pocket Maximum**	
Individual	*Family*	*Individual*	*Family*
$0	$0 per person $0 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)	$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$0	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	$0	100% - No Coverage
Allergy Testing (Non-Injections)	$0	100% - No Coverage
Allergy Injections	$0	100% - No Coverage
Immunizations (other than Preventive Care)	$0	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Maternity Care – All Other Maternity Care	$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	$0	100% - No Coverage
Emergency Care – Emergency Room	$0	$0
Urgent Care	$0	$0 plus Balance Billing
Ground Ambulance	$0	$0 plus Balance Billing
Air Ambulance	$0	$0
Inpatient Hospital Services	$0	100% - No Coverage
Outpatient Hospital Services	$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	$0	100% - No Coverage
Organ and Tissue Transplants	$0	100% - No Coverage
Special Surgical Procedures	$0	100% - No Coverage
Weight Loss Procedures	$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	$0	100% - No Coverage
Skilled Nursing Facility Services	$0	100% - No Coverage
Home Care Services	$0	100% - No Coverage
Hospice Care	$0	100% - No Coverage
Outpatient Mental Health Services	$0	100% - No Coverage
Inpatient Mental Health Services	$0	100% - No Coverage
Emergency Mental Health Services	$0	$0
Outpatient Substance Abuse Services	$0	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Inpatient Substance Abuse Services	$0	100% - No Coverage
Emergency Substance Abuse Services	$0	$0
Outpatient Habilitative Services	$0	100% - No Coverage
Outpatient Rehabilitation	$0	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	$0	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	$0	100 % - No Coverage
Reproductive Care and Family Planning Services	$0	100% - No Coverage
Pediatric Vision	$0	100% - No Coverage
Oral Surgery	$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	$0	100% - No Coverage
Orthognathic Surgery	$0	100% - No Coverage
Pain Management	$0	100% - No Coverage
Approved Clinical Trials	$0 Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	100% - No Coverage
Cancer Drug Therapy	$0	100% - No Coverage
Educational and Nutritional Counseling Services	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	$0	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	$0	100% - No Coverage
Vision Exam (Adult)	$0	100% -

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
		No Coverage

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

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