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 $2,800 Family	$7,300 Individual $14,600 Family	$0 Individual $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 – Emergency Room	20% Coinsurance and Deductible	$0		20% Coinsurance 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 Transplants	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
Special Surgical Procedures	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Home Care Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Hospice Care	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	$30 Copayment No Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Mental Health Services	20% Coinsurance and Deductible	$0	20% Coinsurance and Deductible	20% Coinsurance and Deductible
Outpatient Substance Abuse Services	$30 Copayment No Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Substance Abuse Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Substance Abuse Services	20% Coinsurance and Deductible	$0	20% Coinsurance and Deductible	20% Coinsurance and Deductible
Outpatient Habilitative Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Rehabilitation	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Reproductive Care and Family Planning Services	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
Pediatric Vision	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Oral Surgery	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Orthognathic Surgery	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Pain Management	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	$0 for Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Provider Balance Billing	100% - No Coverage
Cancer Drug Therapy	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Educational Services	20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	 a. $30 Copayment; No Deductible b. 20% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage

Pharmacy	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

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

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