

**MCLAREN HEALTH PLAN COMMUNITY**

**INDIVIDUAL HMO – GOLD – 0 COST SHARING/NATIVE AMERICAN – VIRTUAL CARE PLAN  
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.**

<b>Deductible</b>	<b>Out-of-Pocket Maximum</b>	<b>Pharmacy Deductible</b>
\$0 Individual \$0 Family	\$0 Individual \$0 Family	\$0 Individual \$0 Family

<b>Benefit</b>	<b>In-Network Member Financial Responsibility</b>	<b>Out-of-Network I/T/U Provider Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Preventive Services	\$0	Provider Balance Billing	100% - No Coverage
Diabetic Services	\$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	\$0	Provider Balance Billing	100% - No Coverage
Allergy Testing (Non-Injections)	\$0	Provider Balance Billing	100% - No Coverage
Allergy Injections	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	\$0	Provider Balance Billing	100% - No Coverage
Maternity Care	\$0	Provider Balance Billing	100% - No Coverage
Injectable Drugs Provided in the Physician Office	\$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	\$0	\$0	\$0
Urgent Care	\$0	Provider Balance Billing	Provider Balance Billing

<b>Benefit</b>	<b>In-Network Member Financial Responsibility</b>	<b>Out-of-Network I/T/U Provider Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Ground Ambulance	\$0	\$0	\$0
Inpatient Hospital Services	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	\$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	\$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	\$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	\$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	\$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	\$0	Provider Balance Billing	100% - No Coverage
Home Care Services	\$0	Provider Balance Billing	100% - No Coverage
Hospice Care	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	\$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	\$0	Provider Balance Billing	100% - No Coverage
Emergency Mental Health Services	\$0	\$0	\$0
Outpatient Substance Abuse Services	\$0	Provider Balance Billing	100% - No Coverage
Inpatient Substance Abuse Services	\$0	Provider Balance Billing	100% - No Coverage
Emergency Substance Abuse Services	\$0	\$0	\$0
Outpatient Habilitative Services	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Rehabilitation	\$0	Provider Balance Billing	100% - No Coverage

<b>Benefit</b>	<b>In-Network Member Financial Responsibility</b>	<b>Out-of-Network I/T/U Provider Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Durable Medical Equipment (DME) and Supplies	\$0	Provider Balance Billing	100% - No Coverage
Reproductive Care and Family Planning Services	\$0	Provider Balance Billing	100% - No Coverage
Pediatric Vision	\$0	Provider Balance Billing	100% - No Coverage
Oral Surgery	\$0	Provider Balance Billing	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	\$0	Provider Balance Billing	100% - No Coverage
Orthognathic Surgery	\$0	Provider Balance Billing	100% - No Coverage
Pain Management	\$0	Provider Balance Billing	100% - No Coverage
Approved Clinical Trials	\$0 Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Provider Balance Billing	100% - No Coverage
Cancer Drug Therapy	\$0	Provider Balance Billing	100% - No Coverage
Educational Services	\$0	Provider Balance Billing	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	\$0	Provider Balance Billing	100% - No Coverage
Virtual Care Visit	\$0	Provider Balance Billing	100% - No Coverage

<b>Pharmacy</b>	<b>In-Network Member Financial Responsibility*</b>	<b>Out-of-Network I/T/U Provider Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Tier 1 (Preferred Generic)	\$0	Provider Balance Billing	100% - No Coverage
Tier 2 (Preferred Brand)	\$0	Provider Balance Billing	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	\$0	Provider Balance Billing	100% - No Coverage
Tier 4 (Specialty Drugs)	\$0	Provider Balance Billing	100% - No Coverage
Preventive Drugs	\$0	Provider Balance Billing	100% - No Coverage

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