MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – MHP GOLD VCP

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. Your plan is a Virtual Care Plan.

In-Network Combined Medical and Drug Deductible		**Out-of-Network Combined Medical and Drug Deductible**	
Individual	*Family*	*Individual*	*Family*
$1,400	$1,400 per person $2,800 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		**Out-of-Network Out-of-Pocket Maximum**	
Individual	*Family*	*Individual*	*Family*
$8,000	$8,000 per person $16,000 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 (other than Diabetes Education)	20% Coinsurance after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$40 Copayment No Deductible	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	$50 Copayment No Deductible	100% - No Coverage
Allergy Testing (Non-Injections)	20% Coinsurance after Deductible	100% - No Coverage
Allergy Injections	$0	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance after Deductible	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	100% - No Coverage
Maternity Care – All Other Maternity Care	20% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Injectable Drugs Provided in the Physician Office	20% Coinsurance after Deductible	100% - No Coverage
Emergency Care – Emergency Room	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$60 Copayment No Deductible	$60 Copayment No Deductible plus Balance Billing
Ground Ambulance	20% Coinsurance after Deductible	20% Coinsurance after Deductible plus Balance Billing
Air Ambulance	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Hospital Services	20% Coinsurance after Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	20% Coinsurance after Deductible	100% - No Coverage
Organ and Tissue Transplants	20% Coinsurance after Deductible	100% - No Coverage
Special Surgical Procedures	20% Coinsurance after Deductible	100% - No Coverage
Weight Loss Procedures	20% Coinsurance after Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance after Deductible	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance after Deductible	100% - No Coverage
Home Care Services	20% Coinsurance after Deductible	100% - No Coverage
Hospice Care	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Mental Health Services	$40 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	20% Coinsurance after Deductible	100% - No Coverage
Emergency Mental Health Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Substance Abuse Services	$40 Copayment No Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Inpatient Substance Abuse Services	20% Coinsurance after Deductible	100% - No Coverage
Emergency Substance Abuse Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Habilitative Services	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Rehabilitation	20% Coinsurance after Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	20% Coinsurance after Deductible	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	20% Coinsurance after Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	20% Coinsurance after Deductible	100% - No Coverage
Pediatric Vision	$0	100% - No Coverage
Oral Surgery	20% Coinsurance after Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	20% Coinsurance after Deductible	100% - No Coverage
Orthognathic Surgery	20% Coinsurance after Deductible	100% - No Coverage
Pain Management	20% 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	20% Coinsurance after Deductible	100% - No Coverage
Educational and Nutritional Counseling Services	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	$40 Copayment No Deductible	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	20% Coinsurance after Deductible	100% - No Coverage
Vision Exam (Adult)	20% Coinsurance after Deductible	100% - No Coverage
Virtual Care Visit	$0	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)	$75 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	50% Coinsurance after Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	50% Coinsurance after Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage

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