MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – BRONZE 6500 – 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
\$6,500 Individual	\$8,700 Individual
\$13,000 Family	\$17,400 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	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Maternity Care	 Prenatal Office Visits - \$0 All other Maternity Care - 50% 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
Injectable Drugs Provided in the Physician Office	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	50% Coinsurance and Deductible	\$0	Provider Balance Billing	50% Coinsurance and Deductible plus Balance Billing
Urgent Care	50% Coinsurance and Deductible	\$0	Provider Balance Billing	50% Coinsurance and Deductible plus Balance Billing
Ambulance	50% Coinsurance and Deductible	\$0	Provider Balance Billing	50% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Services	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	50% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Home Care Services	50% 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
Hospice Care	50% Coinsurance	\$0	Provider	100% -
Outpationt Montal	and Deductible 50% Coinsurance	\$0	Balance Billing Provider	No Coverage 100% -
Outpatient Mental Health Services	and Deductible	Ş U		No Coverage
	50% Coinsurance	\$0	Balance Billing Provider	100% -
Inpatient Mental Health Services	and Deductible	ŞU	Balance Billing	No Coverage
	50% Coinsurance	\$0	Provider	50% Coinsurance
Emergency Mental Health Services	and Deductible	Ş U	Balance Billing	and Deductible
nealth Services	and Deductible		Dalatice billing	plus Balance
				Billing
Outpatient	50% Coinsurance	\$0	Provider	100% -
Substance Abuse	and Deductible	7.0	Balance Billing	No Coverage
Services				
Inpatient Substance	50% Coinsurance	\$0	Provider	100% -
Abuse Services	and Deductible		Balance Billing	No Coverage
Emergency	50% Coinsurance	\$0	Provider	50% Coinsurance
Substance Abuse	and Deductible		Balance Billing	and Deductible
Services				plus Balance
				Billing
Outpatient	50% Coinsurance	\$0	Provider	100% -
Habilitative Services	and Deductible		Balance Billing	No Coverage
Outpatient	50% Coinsurance	\$0	Provider	100% -
Rehabilitation	and Deductible		Balance Billing	No Coverage
Durable Medical	50% Coinsurance	\$0	Provider	100% -
Equipment (DME)	and Deductible		Balance Billing	No Coverage
and Supplies				
Reproductive Care	50% Coinsurance	\$0	Provider	100% -
and Family Planning	and Deductible		Balance Billing	No Coverage
Services				
Pediatric Vision	50% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Oral Surgery	50% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Temporomandibular	50% Coinsurance	\$0	Provider	100% -
Joint Syndrome	and Deductible		Balance Billing	No Coverage
(TMJ) Services				

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
Orthognathic	50% Coinsurance	\$0	Provider	100% -
Surgery	and Deductible		Balance Billing	No Coverage
Pain Management	50% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Approved Clinical	Member Cost	\$0 for Member	Provider	100% -
Trials	Sharing	Cost Sharing	Balance Billing	No Coverage
	applicable to	applicable to		
	Routine Patient	Routine Patient		
	Costs outside of	Costs outside of		
	Approved Clinical	Approved Clinical		
	Trial	Trial		
Cancer Drug	50% Coinsurance	\$0	Provider	100% -
Therapy	and Deductible		Balance Billing	No Coverage
Educational Services	50% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Autism Spectrum	50% Coinsurance	\$0	Provider	100% -
Disorder Services	and Deductible		Balance Billing	No Coverage
a. Outpatient				
Mental				
Health				
b. ABA				
(Habilitative)				
Services				

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	\$25 Copayment	\$0	Provider	100% -
Generic)	No Deductible		Balance Billing	No Coverage
Tier 2 (Preferred	\$75 Copayment	\$0	Provider	100% -
Brand)	After Deductible		Balance Billing	No Coverage
Tier 3 (Non-	50% Coinsurance	\$0	Provider	100% -
Preferred Generic and Non-Preferred	and Deductible		Balance Billing	No Coverage
Brand)				
Tier 4 (Specialty	50% Coinsurance	\$0	Provider	100% -
Drugs)	and Deductible		Balance Billing	No Coverage
Preventive Drugs	\$0	\$0	Provider	100% -
			Balance Billing	No Coverage

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