

## MCLAREN HEALTH PLAN COMMUNITY

### INDIVIDUAL HMO – SILVER 5000 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
\$5,000 Individual \$10,000 Family	\$8,150 Individual \$16,300 Family	\$0 Individual \$0 Family

Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	\$0	100% - No Coverage
Diabetic Services	30% Coinsurance and 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)	\$80 Copayment No Deductible	100% - No Coverage
Allergy Testing (Non-Injections)	30% Coinsurance and Deductible	100% - No Coverage
Allergy Injections	\$0	100% - No Coverage
Immunizations (other than Preventive Care)	30% Coinsurance and Deductible	100% - No Coverage
Maternity Care	<ul style="list-style-type: none"> <li>Prenatal Office Visits - \$0</li> <li>All other Maternity Care - 30% Coinsurance and Deductible</li> </ul>	100% - No Coverage
Injectable Drugs Provided in the Physician Office	30% Coinsurance and Deductible	100% - No Coverage
Emergency Care – Emergency Room	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$60 Copayment No Deductible	\$60 Copayment plus Balance Billing No Deductible

<b>Benefit</b>	<b>In-Network Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Ambulance	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Services	30% Coinsurance and Deductible	100% - No Coverage
Outpatient Hospital Services	30% Coinsurance and Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	30% Coinsurance and Deductible	100% - No Coverage
Organ and Tissue Transplants	30% Coinsurance and Deductible	100% - No Coverage
Special Surgical Procedures	30% Coinsurance and Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	30% Coinsurance and Deductible	100% - No Coverage
Skilled Nursing Facility Services	30% Coinsurance and Deductible	100% - No Coverage
Home Care Services	30% Coinsurance and Deductible	100% - No Coverage
Hospice Care	30% Coinsurance and Deductible	100% - No Coverage
Outpatient Mental Health Services	\$40 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	30% Coinsurance and Deductible	100% - No Coverage
Emergency Mental Health Services	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Outpatient Substance Abuse Services	\$40 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	30% Coinsurance and Deductible	100% - No Coverage
Emergency Substance Abuse Services	30% Coinsurance and Deductible	30% Coinsurance and Deductible plus Balance Billing
Outpatient Habilitative Services	30% Coinsurance and Deductible	100% - No Coverage
Outpatient Rehabilitation	30% Coinsurance and Deductible	100% - No Coverage

<b>Benefit</b>	<b>In-Network Member Financial Responsibility</b>	<b>Out-of-Network Member Financial Responsibility</b>
Durable Medical Equipment (DME) and Supplies	30% Coinsurance and Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	30% Coinsurance and Deductible	100% - No Coverage
Pediatric Vision	30% Coinsurance and Deductible	100% - No Coverage
Oral Surgery	30% Coinsurance and Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	30% Coinsurance and Deductible	100% - No Coverage
Orthognathic Surgery	30% Coinsurance and Deductible	100% - No Coverage
Pain Management	30% Coinsurance and 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	30% Coinsurance and Deductible	100% - No Coverage
Educational Services	30% Coinsurance and Deductible	100% - No Coverage
Autism Spectrum Disorder Services <ul style="list-style-type: none"> <li>a. Outpatient Mental Health</li> <li>b. ABA (Habilitative) Services</li> </ul>	<ul style="list-style-type: none"> <li>a. \$40 Copayment; No Deductible</li> <li>b. 30% Coinsurance and Deductible</li> </ul>	100% - No Coverage

<b>Pharmacy</b>	<b>In-Network Member Financial Responsibility*</b>	<b>Out-of-Network Member Financial Responsibility</b>
Tier 1 (Preferred Generic)	\$10 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)	\$150 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	30% Coinsurance and Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage

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