MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – SILVER EXCHANGE 3700 – LIMITED COST SHARING – 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.

Deductible	Out-of-Pocket Maximum	Pharmacy Deductible
\$3,700 Individual	\$8,150 Individual	\$500 Individual
\$7,400 Family	\$16,300 Family	\$1,000 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)	\$65 Copayment after 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 after Deductible	\$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage

2022 Benefit Year 1

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	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
Urgent Care	\$75 Copayment No Deductible	\$0	Provider Balance Billing	\$75 Copayment plus Balance Billing No Deductible
Ambulance	20% Coinsurance and Deductible	\$0	Provider Balance Billing	20% Coinsurance and Deductible plus Balance Billing
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

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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	20% Coinsurance	\$0	Provider	100% -
Procedures	and Deductible		Balance Billing	No Coverage
Breast	20% Coinsurance	\$0	Provider	100% -
Reconstruction	and Deductible		Balance Billing	No Coverage
Following				
Mastectomy	200/ 0 :	40		1000/
Skilled Nursing	20% Coinsurance	\$0	Provider	100% -
Facility Services	and Deductible	4.0	Balance Billing	No Coverage
Home Care Services	20% Coinsurance	\$0	Provider	100% -
	and Deductible	40	Balance Billing	No Coverage
Hospice Care	20% Coinsurance	\$0	Provider	100% -
	and Deductible	40	Balance Billing	No Coverage
Outpatient Mental	\$30 Copayment	\$0	Provider	100% -
Health Services	No Deductible	40	Balance Billing	No Coverage
Inpatient Mental	20% Coinsurance	\$0	Provider	100% -
Health Services	and Deductible	40	Balance Billing	No Coverage
Emergency Mental	20% Coinsurance	\$0	Provider	20% Coinsurance
Health Services	and Deductible		Balance Billing	and Deductible
				plus Balance
Outpationt	¢20 Consument	\$0	Provider	Billing 100% -
Outpatient Substance Abuse	\$30 Copayment No Deductible	ŞU		
Services	No Deductible		Balance Billing	No Coverage
Inpatient Substance	20% Coinsurance	\$0	Provider	100% -
Abuse Services	and Deductible		Balance Billing	No Coverage
Emergency	20% Coinsurance	\$0	Provider	20% Coinsurance
Substance Abuse	and Deductible		Balance Billing	and Deductible
Services				plus Balance
				Billing
Outpatient	20% Coinsurance	\$0	Provider	100% -
Habilitative Services	and Deductible		Balance Billing	No Coverage
Outpatient	20% Coinsurance	\$0	Provider	100% -
Rehabilitation	and Deductible		Balance Billing	No Coverage
Durable Medical	20% Coinsurance	\$0	Provider	100% -
Equipment (DME)	and Deductible		Balance Billing	No Coverage
and Supplies				

2022 Benefit Year 3

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
Reproductive Care and Family Planning	20% Coinsurance and Deductible	\$0	Provider Balance Billing	100% - No Coverage
Services	and Deddelible			_
Pediatric Vision	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Oral Surgery	20% Coinsurance	\$0	Provider	100% -
	and Deductible		Balance Billing	No Coverage
Temporomandibular	20% Coinsurance	\$0	Provider	100% -
Joint Syndrome (TMJ) Services	and Deductible		Balance Billing	No Coverage
Orthognathic	20% Coinsurance	\$0	Provider	100% -
Surgery	and Deductible		Balance Billing	No Coverage
Pain Management	20% 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		1000/
Cancer Drug	20% Coinsurance	\$0	Provider	100% -
Therapy	and Deductible	40	Balance Billing	No Coverage
Educational Services	20% Coinsurance	\$0	Provider	100% -
Autions Considering	and Deductible	ćo	Balance Billing	No Coverage
Autism Spectrum Disorder Services		\$0	Provider	100% -
	2 620		Balance Billing	No Coverage
a. Outpatient Mental	a. \$30			
Health	Copayment; No Deductible			
b. ABA	b. 20%			
(Habilitative)	Coinsurance			
Services	and Deductible			
Virtual Care Visit	\$0	\$0	Provider	100% -
The Gard Gard Viole	, , ,		Balance Billing	No Coverage

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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	\$10 Copayment	\$0	Provider	100% -
Generic)	No Deductible		Balance Billing	No Coverage
Tier 2 (Preferred	\$75 Copayment	\$0	Provider	100% -
Brand)	No Deductible		Balance Billing	No Coverage
Tier 3 (Non-	\$125 Copayment	\$0	Provider	100% -
Preferred Generic	No Deductible		Balance Billing	No Coverage
and Non-Preferred				
Brand)				
Tier 4 (Specialty	40% Coinsurance	\$0	Provider	100% -
Drugs)	and Pharmacy		Balance Billing	No Coverage
	Deductible			
Preventive Drugs	\$0	\$0	Provider	100% -
			Balance Billing	No Coverage

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