

**MCLAREN HEALTH PLAN COMMUNITY**  
**INDIVIDUAL HMO – BRONZE 6500 – 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                 |
|---------------------------------------|---------------------------------------|
| \$6,500 Individual<br>\$13,000 Family | \$9,100 Individual<br>\$18,200 Family |

| Benefit   | In-Network Member Financial Responsibility  | Out-of-Network Member Financial Responsibility      |
|---|---|---|
| Preventive Services                               | \$0   | 100% - No Coverage                                  |
| Diabetic Services                                 | 50% Coinsurance and Deductible  | 100% - No Coverage                                  |
| Primary Care Physician (PCP) Office Visits        | 50% Coinsurance and Deductible  | 100% - No Coverage                                  |
| Specialist Office Visit                           | 50% Coinsurance and Deductible  | 100% - No Coverage                                  |
| Immunizations (other than Preventive Care)        | 50% 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 - 50% Coinsurance and Deductible</li> </ul> | 100% - No Coverage                                  |
| Injectable Drugs Provided in the Physician Office | 50% Coinsurance and Deductible  | 100% - No Coverage                                  |
| Emergency Care – Emergency Room                   | 50% Coinsurance and Deductible  | 50% Coinsurance and Deductible                      |
| Urgent Care                                       | 50% Coinsurance and Deductible  | 50% Coinsurance and Deductible plus Balance Billing |
| Ground Ambulance                                  | 50% Coinsurance and Deductible  | 50% Coinsurance and Deductible plus Balance Billing |
| Air Ambulance                                     | 50% Coinsurance and Deductible  | 50% Coinsurance and Deductible                      |
| Inpatient Hospital Services                       | 50% Coinsurance and Deductible  | 100% - No Coverage                                  |

| <b>Benefit</b>   | <b>In-Network Member Financial Responsibility</b> | <b>Out-of-Network Member Financial Responsibility</b> |
|--|---|---|
| Outpatient Hospital Services   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Diagnostic and Therapeutic Services and Tests (other than Preventive Services) | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Organ and Tissue Transplants   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Special Surgical Procedures  | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Breast Reconstruction Following Mastectomy                                     | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Skilled Nursing Facility Services  | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Home Care Services   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Hospice Care   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Outpatient Mental Health Services  | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Inpatient Mental Health Services   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Emergency Mental Health Services   | 50% Coinsurance and Deductible                    | 50% Coinsurance and Deductible                        |
| Outpatient Substance Abuse Services  | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Inpatient Substance Abuse Services   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Emergency Substance Abuse Services   | 50% Coinsurance and Deductible                    | 50% Coinsurance and Deductible                        |
| Outpatient Habilitative Services   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Outpatient Rehabilitation  | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Durable Medical Equipment (DME) and Supplies                                   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Reproductive Care and Family Planning Services                                 | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Pediatric Vision   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |
| Oral Surgery   | 50% Coinsurance and Deductible                    | 100% - No Coverage                                    |

| <b>Benefit</b>  | <b>In-Network Member Financial Responsibility</b>  | <b>Out-of-Network Member Financial Responsibility</b> |
|---|--|---|
| Temporomandibular Joint Syndrome (TMJ) Services   | 50% Coinsurance and Deductible   | 100% - No Coverage                                    |
| Orthognathic Surgery  | 50% Coinsurance and Deductible   | 100% - No Coverage                                    |
| Pain Management   | 50% 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   | 50% Coinsurance and Deductible   | 100% - No Coverage                                    |
| Educational Services  | 50% 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> | 50% Coinsurance and Deductible   | 100% - No Coverage                                    |
| Virtual Care Visit  | \$0  | 100% - No Coverage                                    |
| Lab Outpatient/Professional Services  | \$10 Copayment   | 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)                             | \$25 Copayment<br>No Deductible                    | 100% - No Coverage                                    |
| Tier 2 (Preferred Brand)                               | \$75 Copayment<br>After Deductible                 | 100% - No Coverage                                    |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | 50% Coinsurance and Deductible                     | 100% - No Coverage                                    |
| Tier 4 (Specialty Drugs)                               | 50% Coinsurance and Deductible                     | 100% - No Coverage                                    |
| Preventive Drugs                                       | \$0  | 100% - No Coverage                                    |

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