**MCLAREN HEALTH PLAN COMMUNITY**

**INDIVIDUAL HMO – SILVER STANDARD – 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 |
|---|---|
| $5,800 Individual<br>$11,600 Family | $8,900 Individual<br>$17,800 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 | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Primary Care Physician (PCP) Office Visits | $40 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | $80 Copayment after Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Allergy Testing (Non-Injections) | 40% 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) | 40% 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 |
|---|---|---|---|---|
| Maternity Care | • Prenatal Office Visits - $0<br>• All other Maternity Care - 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Injectable Drugs Provided in the Physician Office | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Care – Emergency Room | 40% Coinsurance and Deductible | $0 | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Urgent Care | $60 Copayment No Deductible | $0 | Provider Balance Billing | $60 Copayment plus Balance Billing No Deductible |
| Ground Ambulance | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 40% Coinsurance and Deductible plus Balance Billing |
| Ambulance | 40% Coinsurance and Deductible | $0 | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Inpatient Hospital Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Hospital Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Diagnostic and Therapeutic Services and Tests (other than Preventive Services) | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Organ and Tissue Transplants | 40% 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 |
|---|---|---|---|---|
| Special Surgical Procedures | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Breast Reconstruction Following Mastectomy | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Skilled Nursing Facility Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Home Care Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Hospice Care | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Mental Health Services | $40 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Inpatient Mental Health Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Mental Health Services | 40% Coinsurance and Deductible | $0 | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Outpatient Substance Abuse Services | $40 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Inpatient Substance Abuse Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Substance Abuse Services | 40% Coinsurance and Deductible | $0 | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Outpatient Habilitative Services (not including Speech Therapy, Occupational Therapy, and Physical Therapy) | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Rehabilitation (not including Speech Therapy, | 40% 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 |
|---|---|---|---|---|
| Occupational Therapy, and Physical Therapy) | | | | |
| Speech Therapy, Occupational Therapy, and Physical Therapy | $40 Copayment | $0 | Provider Balance Billing | 100% - No Coverage |
| Durable Medical Equipment (DME) and Supplies | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Reproductive Care and Family Planning Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Pediatric Vision | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Oral Surgery | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Temporomandibular Joint Syndrome (TMJ) Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Orthognathic Surgery | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Pain Management | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Approved Clinical Trials | Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | $0 for Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | Provider Balance Billing | 100% - No Coverage |
| Cancer Drug Therapy | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Educational Services | 40% Coinsurance and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Autism Spectrum Disorder Services | | $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 |
|---|---|---|---|---|
| a. Outpatient Mental Health<br>b. ABA (Habilitative) Services | a. $40 Copayment; No Deductible<br>b. 40% Coinsurance and Deductible | | | |

| 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 Generic) | $20 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 2 (Preferred Brand) | $40 Copayment No Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | $80 Copayment and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | $350 Copayment and Deductible | $0 | Provider Balance Billing | 100% - No Coverage |
| Preventive Drugs | $0 | $0 | Provider Balance Billing | 100% - No Coverage |

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