**MCLAREN HEALTH PLAN COMMUNITY**

**INDIVIDUAL HMO – SILVER STANDARD – 0 COST SHARING/NATIVE AMERICAN**
**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 |
|---|---|
| $0 Individual<br>$0 Family | $0 Individual<br>$0 Family |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network I/T/U Provider Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|---|
| Preventive Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Diabetic Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Primary Care Physician (PCP) Office Visits | $0 | Provider Balance Billing | 100% - No Coverage |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | $0 | Provider Balance Billing | 100% - No Coverage |
| Allergy Testing (Non-Injections) | $0 | Provider Balance Billing | 100% - No Coverage |
| Allergy Injections | $0 | Provider Balance Billing | 100% - No Coverage |
| Immunizations (other than Preventive Care) | $0 | Provider Balance Billing | 100% - No Coverage |
| Maternity Care | $0 | Provider Balance Billing | 100% - No Coverage |
| Injectable Drugs Provided in the Physician Office | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Care – Emergency Room | $0 | $0 | $0 |
| Urgent Care | $0 | Provider Balance Billing | Provider Balance Billing |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network I/T/U Provider Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|---|
| Ground Ambulance | $0 | Provider Balance Billing | Provider Balance Billing |
| Air Ambulance | $0 | $0 | $0 |
| Inpatient Hospital Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Hospital Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Diagnostic and Therapeutic Services and Tests (other than Preventive Services) | $0 | Provider Balance Billing | 100% - No Coverage |
| Organ and Tissue Transplants | $0 | Provider Balance Billing | 100% - No Coverage |
| Special Surgical Procedures | $0 | Provider Balance Billing | 100% - No Coverage |
| Breast Reconstruction Following Mastectomy | $0 | Provider Balance Billing | 100% - No Coverage |
| Skilled Nursing Facility Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Home Care Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Hospice Care | $0 | Provider Balance Billing | 100% - No Coverage |
| Outpatient Mental Health Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Inpatient Mental Health Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Mental Health Services | $0 | $0 | $0 |
| Outpatient Substance Abuse Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Inpatient Substance Abuse Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Emergency Substance Abuse Services | $0 | $0 | $0 |
| Outpatient Habilitative Services (not including Speech Therapy, | $0 | Provider Balance Billing | 100% - No Coverage |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network I/T/U Provider Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|---|
| Occupational Therapy, and Physical Therapy) | | | |
| Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy) | $0 | Provider Balance Billing | 100% - No Coverage |
| Speech Therapy, Occupational Therapy, and Physical Therapy | $0 | Provider Balance Billing | 100% - No Coverage |
| Durable Medical Equipment (DME) and Supplies | $0 | Provider Balance Billing | 100% - No Coverage |
| Reproductive Care and Family Planning Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Pediatric Vision | $0 | Provider Balance Billing | 100% - No Coverage |
| Oral Surgery | $0 | Provider Balance Billing | 100% - No Coverage |
| Temporomandibular Joint Syndrome (TMJ) Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Orthognathic Surgery | $0 | Provider Balance Billing | 100% - No Coverage |
| Pain Management | $0 | Provider Balance Billing | 100% - No Coverage |
| Approved Clinical Trials | $0 Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | Provider Balance Billing | 100% - No Coverage |
| Cancer Drug Therapy | $0 | Provider Balance Billing | 100% - No Coverage |
| Educational Services | $0 | Provider Balance Billing | 100% - No Coverage |
| Autism Spectrum Disorder Services | $0 | Provider Balance Billing | 100% - No Coverage |

| Benefit | In-Network 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 | | | |

| Pharmacy | In-Network Member Financial Responsibility* | Out-of-Network I/T/U Provider Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|---|
| Tier 1 (Preferred Generic) | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 2 (Preferred Brand) | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | $0 | Provider Balance Billing | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | $0 | Provider Balance Billing | 100% - No Coverage |
| Preventive Drugs | $0 | Provider Balance Billing | 100% - No Coverage |

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