**MCLAREN HEALTH PLAN COMMUNITY**

**INDIVIDUAL HMO – SILVER STANDARD 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 | Out-of-Network Member Financial Responsibility |
|---|---|---|
| Preventive Services | $0 | 100% - No Coverage |
| Diabetic Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Primary Care Physician (PCP) Office Visits | $40 Copayment<br>No Deductible | 100% - No Coverage |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | $80 Copayment<br>No Deductible | 100% - No Coverage |
| Allergy Testing (Non-Injections) | 40% Coinsurance and Deductible | 100% - No Coverage |
| Allergy Injections | $0<br>after Deductible | 100% - No Coverage |
| Immunizations (other than Preventive Care) | 40% Coinsurance and Deductible | 100% - No Coverage |
| Maternity Care | • Prenatal Office Visits - $0<br>• All other Maternity Care - 40% Coinsurance and Deductible | 100% - No Coverage |
| Injectable Drugs Provided in the Physician Office | 40% Coinsurance and Deductible | 100% - No Coverage |
| Emergency Care – Emergency Room | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Urgent Care | $60 Copayment<br>No Deductible | $60 Copayment plus Balance Billing<br>No Deductible |
| Ground Ambulance | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible plus Balance Billing |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|
| Air Ambulance | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Inpatient Hospital Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Outpatient Hospital Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Diagnostic and Therapeutic Services and Tests (other than Preventive Services) | 40% Coinsurance and Deductible | 100% - No Coverage |
| Organ and Tissue Transplants | 40% Coinsurance and Deductible | 100% - No Coverage |
| Special Surgical Procedures | 40% Coinsurance and Deductible | 100% - No Coverage |
| Breast Reconstruction Following Mastectomy | 40% Coinsurance and Deductible | 100% - No Coverage |
| Skilled Nursing Facility Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Home Care Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Hospice Care | 40% Coinsurance and Deductible | 100% - No Coverage |
| Outpatient Mental Health Services | $40 Copayment No Deductible | 100% - No Coverage |
| Inpatient Mental Health Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Emergency Mental Health Services | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Outpatient Substance Abuse Services | $40 Copayment No Deductible | 100% - No Coverage |
| Inpatient Substance Abuse Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Emergency Substance Abuse Services | 40% Coinsurance and Deductible | 40% Coinsurance and Deductible |
| Outpatient Habilitative Services (not including Speech Therapy, Occupational Therapy, and Physical Therapy) | 40% Coinsurance and Deductible | 100% - No Coverage |
| Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy) | 40% Coinsurance and Deductible | 100% - No Coverage |

| Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|
| Speech Therapy, Occupational Therapy, and Physical Therapy | $40 Copayment<br>No Deductible | 100% - No Coverage |
| Durable Medical Equipment (DME) and Supplies | 40% Coinsurance and Deductible | 100% - No Coverage |
| Reproductive Care and Family Planning Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Pediatric Vision | 40% Coinsurance and Deductible | 100% - No Coverage |
| Oral Surgery | 40% Coinsurance and Deductible | 100% - No Coverage |
| Temporomandibular Joint Syndrome (TMJ) Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Orthognathic Surgery | 40% Coinsurance and Deductible | 100% - No Coverage |
| Pain Management | 40% 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 | 40% Coinsurance and Deductible | 100% - No Coverage |
| Educational Services | 40% Coinsurance and Deductible | 100% - No Coverage |
| Autism Spectrum Disorder Services<br>a. Outpatient Mental Health<br>b. ABA (Habilitative) Services | a. $40 Copayment; No Deductible<br>b. 40% Coinsurance and Deductible | 100% - No Coverage |

| Pharmacy | In-Network Member Financial Responsibility* | Out-of-Network Member Financial Responsibility |
|---|---|---|
| Tier 1 (Preferred Generic) | $20 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 2 (Preferred Brand) | $40 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | $80 Copayment and Deductible | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | $350 Copayment Coinsurance and Deductible | 100% - No Coverage |

| | | |
|---|---|---|
| Preventive Drugs | $0 | 100% - No Coverage |

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