

**MCLAREN HEALTH PLAN COMMUNITY**

**INDIVIDUAL HMO – MHP EXPANDED BRONZE 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.

| <b>In-Network Combined Medical and Drug Deductible</b> |  | <b>Out-of-Network Combined Medical and Drug Deductible</b> |                |
|--|--|--|----------------|
| <i>Individual</i>                                      | <i>Family</i>                            | <i>Individual</i>  | <i>Family</i>  |
| \$7,500  | \$7,500 per person<br>\$15,000 per group | Not Applicable   | Not Applicable |

| <b>In-Network Out-of-Pocket Maximum</b> |  | <b>Out-of-Network Out-of-Pocket Maximum</b> |                |
|---|--|---|----------------|
| <i>Individual</i>                       | <i>Family</i>                            | <i>Individual</i>                           | <i>Family</i>  |
| \$9,200                                 | \$9,200 per person<br>\$18,400 per group | Not Applicable                              | Not Applicable |

| <b>IHCP Providers</b>  |
|--|
| Native American limited plans have zero cost sharing when you see an IHCP provider or with IHCP referral to a non-IHCP provider. |

| <b>Medical Benefit</b>  | <b>In-Network Member Financial Responsibility</b> | <b>Out-of-Network Member Financial Responsibility*</b> |
|---|---|--|
| Preventive Services   | \$0   | 100% - No Coverage                                     |
| Diabetic Services and Supplies (other than Diabetes Education)              | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |
| Primary Care Physician (PCP) Office Visits                                  | \$50 Copayment<br>No Deductible                   | 100% - No Coverage                                     |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | \$100 Copayment<br>No Deductible                  | 100% - No Coverage                                     |
| Allergy Testing (Non-Injections)  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |
| Allergy Injections  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |

| <b>Medical Benefit</b>   | <b>In-Network Member Financial Responsibility</b> | <b>Out-of-Network Member Financial Responsibility*</b>   |
|--|---|--|
| Immunizations (other than Preventive Care)                                     | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Maternity Care – Preventive Prenatal and Postnatal Office Visits               | \$0   | 100% - No Coverage                                       |
| Maternity Care – All Other Maternity Care                                      | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Injectable Drugs Provided in the Physician Office                              | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Emergency Care – Emergency Room  | 50% Coinsurance after Deductible                  | 50% Coinsurance after Deductible                         |
| Urgent Care  | \$75 Copayment<br>No Deductible                   | \$75 Copayment<br>No Deductible<br>plus Balance Billing  |
| Ground Ambulance   | 50% Coinsurance after Deductible                  | 50% Coinsurance after Deductible<br>plus Balance Billing |
| Air Ambulance  | 50% Coinsurance after Deductible                  | 50% Coinsurance after Deductible                         |
| Inpatient Hospital Services  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Outpatient Hospital Services   | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Diagnostic and Therapeutic Services and Tests (other than Preventive Services) | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Organ and Tissue Transplants   | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Special Surgical Procedures  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Weight Loss Procedures   | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Breast Reconstruction Following Mastectomy                                     | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Skilled Nursing Facility Services  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Home Care Services   | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |
| Hospice Care   | 50% Coinsurance after Deductible                  | 100% - No Coverage                                       |

| <b>Medical Benefit</b>  | <b>In-Network Member Financial Responsibility</b>  | <b>Out-of-Network Member Financial Responsibility*</b> |
|---|--|--|
| Outpatient Mental Health Services   | \$50 Copayment<br>No Deductible  | 100% - No Coverage                                     |
| Inpatient Mental Health Services  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Emergency Mental Health Services  | 50% Coinsurance after Deductible   | 50% Coinsurance after Deductible                       |
| Outpatient Substance Abuse Services   | \$50 Copayment<br>No Deductible  | 100% - No Coverage                                     |
| Inpatient Substance Abuse Services  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Emergency Substance Abuse Services  | 50% Coinsurance after Deductible   | 50% Coinsurance after Deductible                       |
| Outpatient Habilitative Services (not including Speech Therapy, Occupational Therapy, and Physical Therapy) | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy)        | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Speech Therapy, Occupational Therapy, and Physical Therapy  | \$50 Copayment<br>No Deductible  | 100% - No Coverage                                     |
| Durable Medical Equipment (DME) and Supplies  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Prosthetics, Orthotics and Corrective Appliances  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Reproductive Care and Family Planning Services  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Pediatric Vision  | \$0  | 100% - No Coverage                                     |
| Oral Surgery  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Temporomandibular Joint Syndrome (TMJ) Services   | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Orthognathic Surgery  | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Pain Management   | 50% Coinsurance after Deductible   | 100% - No Coverage                                     |
| Approved Clinical Trials  | Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial | 100% - No Coverage                                     |

| <b>Medical Benefit</b>   | <b>In-Network Member Financial Responsibility</b> | <b>Out-of-Network Member Financial Responsibility*</b> |
|--|---|--|
| Cancer Drug Therapy  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |
| Educational and Nutritional Counseling Services  | \$0   | 100% - No Coverage                                     |
| Autism Spectrum Disorder Services - Outpatient Mental Health                           | \$50 Copayment<br>No Deductible                   | 100% - No Coverage                                     |
| Autism Spectrum Disorder Services - All other Autism Services (including ABA Services) | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |
| Vision Exam (Adult)  | 50% Coinsurance after Deductible                  | 100% - No Coverage                                     |

\*Note - except for balance billing, Cost-Sharing for Out-of-Network Covered Services applies towards the In-Network Cost-Sharing (e.g., Deductible and Out-of-Pocket Maximum, when applicable).

| <b>Pharmacy Benefit</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)                               | \$50 Copayment<br>after Deductible                 | 100% - No Coverage                                    |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | \$100 Copayment<br>after Deductible                | 100% - No Coverage                                    |
| Tier 4 (Specialty Drugs)                               | \$500 Copayment<br>after Deductible                | 100% - No Coverage                                    |
| Preventive Drugs                                       | \$0  | 100% - No Coverage                                    |

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