MCLAREN HEALTH PLAN COMMUNITY INDIVIDUAL HMO – MHP BRONZE

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.

In-Network Combined Medical and Drug Deductible		Out-of-Network Combined Medical and Drug Deductible	
Individual	Family	Individual	Family
\$8,250	\$8,250 per person \$16,500 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		Out-of-Network Out-of-Pocket Maximum	
Individual	Family	Individual	Family
\$10,150	\$10,150 per person \$20,300 per group	Not Applicable	Not Applicable

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Preventive Services	\$0	100% - No Coverage
Diabetic Services and Supplies	50% Coinsurance after	100% - No Coverage
(other than Diabetes Education)	Deductible	
Primary Care Physician (PCP)	50% Coinsurance after	100% - No Coverage
Office Visits	Deductible	
Specialist Office Visit (other	50% Coinsurance after	100% - No Coverage
than Allergy Injections)	Deductible	
Allergy Testing (Non-Injections)	50% Coinsurance after	100% - No Coverage
	Deductible	
Allergy Injections	\$0	100% - No Coverage
Immunizations (other than	50% Coinsurance after	100% - No Coverage
Preventive Care)	Deductible	
Maternity Care – Preventive	\$0	100% - No Coverage
Prenatal and Postnatal Office		
Visits		
Maternity Care – All Other	50% Coinsurance after	100% - No Coverage
Maternity Care	Deductible	
Injectable Drugs Provided in the	50% Coinsurance after	100% - No Coverage
Physician Office	Deductible	
Emergency Care – Emergency	50% Coinsurance after	50% Coinsurance after
Room	Deductible	Deductible

2026 Benefit Year 1

Medical Benefit	In-Network Member	Out-of-Network Member
	Financial Responsibility	Financial Responsibility*
Urgent Care	50% Coinsurance after	50% Coinsurance after
	Deductible	Deductible
		plus Balance Billing
Ground Ambulance	50% Coinsurance after	50% Coinsurance after
	Deductible	Deductible
		plus Balance Billing
Air Ambulance	50% Coinsurance after	50% Coinsurance after
	Deductible	Deductible
Inpatient Hospital Services	50% Coinsurance after	100% - No Coverage
	Deductible	
Outpatient Hospital Services	50% Coinsurance after	100% - No Coverage
	Deductible	
Diagnostic and Therapeutic	50% Coinsurance after	100% - No Coverage
Services and Tests (other than	Deductible	
Preventive Services or		
Laboratory		
Outpatient/Professional		
Services)		
Laboratory Outpatient/	50% Coinsurance after	100% - No Coverage
Professional Services	Deductible	
Organ and Tissue Transplants	50% Coinsurance after	100% - No Coverage
	Deductible	
Special Surgical Procedures	50% Coinsurance after	100% - No Coverage
	Deductible	
Weight Loss Procedures	50% Coinsurance after	100% - No Coverage
	Deductible	
Breast Reconstruction Following	50% Coinsurance after	100% - No Coverage
Mastectomy	Deductible	
Skilled Nursing Facility Services	50% Coinsurance after	100% - No Coverage
	Deductible	
Home Care Services	50% Coinsurance after	100% - No Coverage
	Deductible	
Hospice Care	50% Coinsurance after	100% - No Coverage
	Deductible	
Outpatient Mental Health	50% Coinsurance after	100% - No Coverage
Services	Deductible	
Inpatient Mental Health	50% Coinsurance after	100% - No Coverage
Services	Deductible	
Emergency Mental Health	50% Coinsurance after	50% Coinsurance after
Services	Deductible	Deductible

2026 Benefit Year 2

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Outpatient Substance Abuse	50% Coinsurance after	100% - No Coverage
Services	Deductible	100% - NO Coverage
Inpatient Substance Abuse	50% Coinsurance after	100% - No Coverage
Services	Deductible	
Emergency Substance Abuse	50% Coinsurance after	50% Coinsurance after
Services	Deductible	Deductible
Outpatient Habilitative Services	50% Coinsurance after Deductible	100% - No Coverage
Outpatient Rehabilitation	50% Coinsurance after 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
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% Coinsurance after 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

2026 Benefit Year 3

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Virtual Benefit	\$0	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).

Pharmacy Benefit	In-Network Member Financial Responsibility*	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	\$20 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	\$100 Copayment after Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	50% Coinsurance after Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	50% Coinsurance after Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage

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

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