MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – MHP BRONZE SAVER (EXPANDED)

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. This plan is intended to meet the requirements of a High Deductible Health Plan.

In-Network Combined Medical and Drug Deductible		**Out-of-Network Combined Medical and Drug Deductible**	
Individual	*Family*	*Individual*	*Family*
$8,500	$8,500 per person $17,000 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		**Out-of-Network Out-of-Pocket Maximum**	
Individual	*Family*	*Individual*	*Family*
$8,500	$8,500 per person $17,000 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 (other than Diabetes Education)	No charge after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	No charge after Deductible	100% - No Coverage
Specialist Office Visit	No charge after Deductible	100% - No Coverage
Immunizations (other than Preventive Care)	No charge after Deductible	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	100% - No Coverage
Maternity Care – All Other Maternity Care	No charge after Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	No charge after Deductible	100% - No Coverage
Emergency Care – Emergency Room	No charge after Deductible	No charge after Deductible
Urgent Care	No charge after Deductible	No charge after Deductible but subject to Balance Billing

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Ground Ambulance	No charge after Deductible	No charge after Deductible but subject to Balance Billing
Air Ambulance	No charge after Deductible	No charge after Deductible
Inpatient Hospital Services	No charge after Deductible	100% - No Coverage
Outpatient Hospital Services	No charge after Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	No charge after Deductible	100% - No Coverage
Organ and Tissue Transplants	No charge after Deductible	100% - No Coverage
Special Surgical Procedures	No charge after Deductible	100% - No Coverage
Weight Loss Procedures	No charge after Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	No charge after Deductible	100% - No Coverage
Skilled Nursing Facility Services	No charge after Deductible	100% - No Coverage
Home Care Services	No charge after Deductible	100% - No Coverage
Hospice Care	No charge after Deductible	100% - No Coverage
Outpatient Mental Health Services	No charge after Deductible	100% - No Coverage
Inpatient Mental Health Services	No charge after Deductible	100% - No Coverage
Emergency Mental Health Services	No charge after Deductible	No charge after Deductible
Outpatient Substance Abuse Services	No charge after Deductible	100% - No Coverage
Inpatient Substance Abuse Services	No charge after Deductible	100% - No Coverage
Emergency Substance Abuse Services	No charge after Deductible	No charge after Deductible
Outpatient Habilitative Services	No charge after Deductible	100% - No Coverage
Outpatient Rehabilitation	No charge after Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	No charge after Deductible	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	No charge after Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	No charge after Deductible	100% - No Coverage
Pediatric Vision – Routine Eye Exam for Children	$0	100% - No Coverage
Pediatric Vision – All Other	No charge after Deductible	
Oral Surgery	No charge after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Temporomandibular Joint Syndrome (TMJ) Services	No charge after Deductible	100% - No Coverage
Orthognathic Surgery	No charge after Deductible	100% - No Coverage
Pain Management	No charge after Deductible	100% - No Coverage
Approved Clinical Trials	No charge after Deductible for Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	100% - No Coverage
Cancer Drug Therapy	No charge after Deductible	100% - No Coverage
Educational and Nutritional Counseling Services	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	No charge after Deductible	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	No charge after Deductible	100% - No Coverage
Vision Exam (Adult)	No charge 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).

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

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