MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – MHP SILVER EXCHANGE 94%

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*
$275	$275 per person $550 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		**Out-of-Network Out-of-Pocket Maximum**	
Individual	*Family*	*Individual*	*Family*
$1,350	$1,350 per person $2,700 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)	10% Coinsurance after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$20 Copayment No Deductible	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	$30 Copayment No Deductible	100% - No Coverage
Allergy Testing (Non-Injections)	10% Coinsurance after Deductible	100% - No Coverage
Allergy Injections	$0	100% - No Coverage
Immunizations (other than Preventive Care)	10% Coinsurance after Deductible	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	100% - No Coverage
Maternity Care – All Other Maternity Care	10% Coinsurance after Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	10% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Emergency Care – Emergency Room	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Urgent Care	$25 Copayment No Deductible	$25 Copayment No Deductible plus Balance Billing
Ground Ambulance	10% Coinsurance after Deductible	10% Coinsurance after Deductible plus Balance Billing
Air Ambulance	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	100% - No Coverage
Outpatient Hospital Services	10% Coinsurance after Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	10% Coinsurance after Deductible	100% - No Coverage
Organ and Tissue Transplants	10% Coinsurance after Deductible	100% - No Coverage
Special Surgical Procedures	10% Coinsurance after Deductible	100% - No Coverage
Weight Loss Procedures	10% Coinsurance after Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	10% Coinsurance after Deductible	100% - No Coverage
Skilled Nursing Facility Services	10% Coinsurance after Deductible	100% - No Coverage
Home Care Services	10% Coinsurance after Deductible	100% - No Coverage
Hospice Care	10% Coinsurance after Deductible	100% - No Coverage
Outpatient Mental Health Services	$20 Copayment No Deductible	100% - No Coverage
Inpatient Mental Health Services	10% Coinsurance after Deductible	100% - No Coverage
Emergency Mental Health Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Outpatient Substance Abuse Services	$20 Copayment No Deductible	100% - No Coverage
Inpatient Substance Abuse Services	10% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Emergency Substance Abuse Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Outpatient Habilitative Services	10% Coinsurance after Deductible	100% - No Coverage
Outpatient Rehabilitation	10% Coinsurance after Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	10% Coinsurance after Deductible	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	10% Coinsurance after Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	10% Coinsurance after Deductible	100% - No Coverage
Pediatric Vision	$0	100% - No Coverage
Oral Surgery	10% Coinsurance after Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	10% Coinsurance after Deductible	100% - No Coverage
Orthognathic Surgery	10% Coinsurance after Deductible	100% - No Coverage
Pain Management	10% 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	10% Coinsurance after Deductible	100% - No Coverage
Educational and Nutritional Counseling Services	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	$20 Copayment No Deductible	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	10% Coinsurance after Deductible	100% - No Coverage
Vision Exam (Adult)	10% Coinsurance after Deductible	100% - No Coverage
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)	$15 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$55 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	$100 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	50% Coinsurance after Deductible ($254.75 Coinsurance Maximum after Deductible per 30-day supply for Antineoplastic medication)**	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage

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

**"Antineoplastic medication" means a medication used to kill, slow, or prevent the growth of cancerous cells. The Coinsurance Maximum is subject to the increase specified in MCL 500.3406ff(1)(b) and will be adjusted in your benefit effective January 1, 2027.