MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – BRONZE 6500 – 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.

Deductible	Out-of-Pocket Maximum
$6,500 Individual $13,000 Family	$9,100 Individual $18,200 Family

Benefit	In-Network Member Financial Responsibility	In-Network I/T/U Provider Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	$0	$0	Provider Balance Billing	100% - No Coverage
Diabetic Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Maternity Care	• Prenatal Office Visits - $0 • All other Maternity Care - 50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	In-Network I/T/U Provider Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Injectable Drugs Provided in the Physician Office	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	50% Coinsurance and Deductible	$0	50% Coinsurance and Deductible	50% Coinsurance and Deductible
Urgent Care	50% Coinsurance and Deductible	$0	Provider Balance Billing	50% Coinsurance and Deductible plus Balance Billing
Ground Ambulance	50% Coinsurance and Deductible	$0	Provider Balance Billing	50% Coinsurance and Deductible plus Balance Billing
Air Ambulance	50% Coinsurance and Deductible	$0	50% Coinsurance and Deductible	50% Coinsurance and Deductible
Inpatient Hospital Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Home Care Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	In-Network I/T/U Provider Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Hospice Care	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Mental Health Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Mental Health Services	50% Coinsurance and Deductible	$0	50% Coinsurance and Deductible	50% Coinsurance and Deductible
Outpatient Substance Abuse Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Substance Abuse Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Substance Abuse Services	50% Coinsurance and Deductible	$0	50% Coinsurance and Deductible	50% Coinsurance and Deductible
Outpatient Habilitative Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Rehabilitation	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Reproductive Care and Family Planning Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Pediatric Vision	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Oral Surgery	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Orthognathic Surgery	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Pain Management	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	In-Network I/T/U Provider Member Financial Responsibility	Out-of-Network I/T/U Provider Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	$0 for Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Provider Balance Billing	100% - No Coverage
Cancer Drug Therapy	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Educational Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Lab Outpatient/Professional Services	$10 Copayment	$0	Provider Balance Billing	100% - No Coverage

Pharmacy	In-Network Member	In-Network I/T/U Provider Member	Out-of-Network I/T/U Provider Member	Out-of-Network Member

	Financial Responsibility*	Financial Responsibility	Financial Responsibility	Financial Responsibility
Tier 1 (Preferred Generic)	$25 Copayment No Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 2 (Preferred Brand)	$75 Copayment After Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 4 (Specialty Drugs)	50% Coinsurance and Deductible	$0	Provider Balance Billing	100% - No Coverage
Preventive Drugs	$0	$0	Provider Balance Billing	100% - No Coverage

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