MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO – 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.

Deductible	Out-of-Pocket Maximum
$9,100 Individual $18,200 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	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Primary Care Physician (PCP) Office Visits	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Specialist Office Visit	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Immunizations (other than Preventive Care)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Maternity Care	• Prenatal Office Visits - $0 • All other Maternity Care - No charge after 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	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Care – Emergency Room	No charge after Deductible	$0	No charge after Deductible	No charge after Deductible
Urgent Care	No charge after Deductible	$0	Provider Balance Billing	No charge after Deductible plus Balance Billing
Ground Ambulance	No charge after Deductible	$0	Provider Balance Billing	No charge after Deductible plus Balance Billing
Air Ambulance	No charge after Deductible	$0	No charge after Deductible	No charge after Deductible
Inpatient Hospital Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Hospital Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Organ and Tissue Transplants	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Special Surgical Procedures	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Breast Reconstruction Following Mastectomy	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Skilled Nursing Facility Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Home Care Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Hospice Care	No charge after 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
Outpatient Mental Health Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Mental Health Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Mental Health Services	No charge after Deductible	$0	No charge after Deductible	No charge after Deductible
Outpatient Substance Abuse Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Inpatient Substance Abuse Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Emergency Substance Abuse Services	No charge after Deductible	$0	No charge after Deductible	No charge after Deductible
Outpatient Habilitative Services (not including Speech Therapy, Occupational Therapy, and Physical Therapy)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Outpatient Rehabilitation (not including Speech Therapy, Occupational Therapy, and Physical Therapy)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Speech Therapy, Occupational Therapy, and Physical Therapy	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	No charge after 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
Reproductive Care and Family Planning Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Pediatric Vision	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Oral Surgery	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Orthognathic Surgery	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Pain Management	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
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	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Educational Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage

Pharmacy	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
Tier 1 (Preferred Generic)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 2 (Preferred Brand)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	No charge after Deductible	$0	Provider Balance Billing	100% - No Coverage
Tier 4 (Specialty Drugs)	No charge after 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.