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

**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. Your plan is a Virtual Care Plan.**

| In-Network Medical Deductible | | Out-of-Network Medical Deductible | |
|---|---|---|---|
| *Individual* | *Family* | *Individual* | *Family* |
| $250 | $250 per person<br>$500 per group | Not Applicable | Not Applicable |

| In-Network Pharmacy Deductible | | Out-of-Network Pharmacy Deductible | |
|---|---|---|---|
| *Individual* | *Family* | *Individual* | *Family* |
| $0 | $0 per person<br>$0 per group | Not Applicable | Not Applicable |

| In-Network Out-of-Pocket Maximum | | Out-of-Network Out-of-Pocket Maximum | |
|---|---|---|---|
| *Individual* | *Family* | *Individual* | *Family* |
| $1,000 | $1,000 per person<br>$2,000 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 (other than Diabetes Education) | 10% Coinsurance after Deductible | 100% - No Coverage |
| Primary Care Physician (PCP) Office Visits | $10 Copayment<br>No Deductible | 100% - No Coverage |
| Specialist Office Visit (other than Allergy Testing and Allergy Injections) | $15 Copayment<br>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 |

| Medical Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility* |
|---|---|---|
| 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 |
| Emergency Care – Emergency Room | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible |
| Urgent Care | $25 Copayment<br>No Deductible | $25 Copayment<br>No Deductible<br>plus Balance Billing |
| Ground Ambulance | 10% Coinsurance after Deductible | 10% Coinsurance after Deductible<br>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 | $10 Copayment<br>No Deductible | 100% - No Coverage |

| Medical Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility* |
|---|---|---|
| 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 | $10 Copayment No Deductible | 100% - No Coverage |
| Inpatient Substance Abuse Services | 10% Coinsurance after Deductible | 100% - No Coverage |
| 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 | $10 Copayment No Deductible | 100% - No Coverage |
| Autism Spectrum Disorder Services - All other Autism | 10% Coinsurance after Deductible | 100% - No Coverage |

| Medical Benefit | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility* |
|---|---|---|
| Services (including ABA Services) | | |
| Vision Exam (Adult) | 10% Coinsurance after Deductible | 100% - No Coverage |
| Virtual Care Visit | $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) | $5 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 2 (Preferred Brand) | $50 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | $100 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | 30% Coinsurance<br>No Deductible | 100% - No Coverage |
| Preventive Drugs | $0 | 100% - No Coverage |

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