MCLAREN HEALTH ADVANTAGE PREMIER PLUS – 2027

SCHEDULE OF MEMBER COST SHARING

This document is a part of your McLaren Health Advantage Medical Benefits Document. It provides you with detailed information about member out-of-pocket expenses and certain limitations of coverage. It does not include all conditions of coverage; refer to your Health Benefits booklet for additional terms of coverage, especially preauthorization requirements.

	Tier 1 Providers	**Tier 2 Providers**	**Out-of-Network All other Hospitals and Physicians**
Annual Deductible	$200 Individual $400 Family	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family
Medical Coinsurance Out-of-Pocket Maximum	$500 Individual $1,000 Family	$3,000 Individual $6,000 family	$3,000 Individual $6,000 family
Total Out-of- Pocket Maximum*	$9,200 Individual $18,400 Family		$13,000 Individual $26,000 Family

*Your total OOPM can be met by satisfying your deductible(s) coinsurance maximum amounts and applicable medical and pharmacy copays through a calendar year.

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Preventive Services	$0	100% No Coverage	100% No Coverage	
Diabetic Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Primary Care Physician (PCP) Office Visits	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Specialist Office Visit	$30 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Allergy Testing and Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Immunizations (other than Preventive Care)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Maternity Care (Prenatal and Postnatal Visits, Delivery and Routine Nursery Care)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Injectable Drugs Provided in the Physician Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Spinal Treatment	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 24 visits per Plan Year

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Emergency Care – Emergency Room	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	
Urgent Care	$25 Copayment No Deductible	$25 Copayment No Deductible	$25 Copayment Plus Balance Bill No Deductible	
Ambulance	100%	100%	Provider Balance Bill*	*Surprise billing rules prohibiting balance billing may apply for certain air ambulance services
Inpatient and Long-Term Acute Hospital Services (including Consultations by a Physician)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	When McLaren Hospital (facility) is used, Deductible is waived for the facility service. However, you may be billed for professional (provider) services to which applicable Deductible and Coinsurance will apply.
Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Diagnostic and Therapeutic Services and Tests (e.g., therapeutic radiology, diagnostic radiology, diagnostic laboratory and pathology services)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	For laboratory services, only Domestic and Preferred Laboratory Providers[11] are considered In-Network. All other laboratories are Out-of-Network with Provider Balance Bill.

[1] JVHL is the Preferred Laboratory Provider.

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Organ and Tissue Transplants	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Special Surgical Procedures	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Breast Reconstruction Following Mastectomy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Skilled Nursing Facility Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 120 days per Plan Year
Home Care Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Hospice Care	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Outpatient Mental Health Services	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Mental Health Services (Including Partial Treatment Programs and Residential Mental Health Treatment)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Emergency Mental Health Services	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Outpatient Substance Abuse Services	$15 Copayment No Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Inpatient Substance Abuse Services (Including Partial Hospitalization and Residential Substance Abuse Treatment)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Emergency Substance Abuse Services	$100 Copayment No Deductible	$100 Copayment No Deductible	$100 Copayment No Deductible	
Outpatient Habilitation Services	100% Not Covered	100% Not Covered	100% Not Covered	
Outpatient Rehabilitation (Physical, Speech and Occupational Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Limited to 60 visits, per condition, per Plan Year
Durable Medical Equipment (DME) and Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if: • Purchase price is $5,000 or more • Rental is $500 or more per month
Prosthetics, Orthotics and Corrective Appliances	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	Preauthorization required if purchase price is $5,000 or more
Reproductive Care and Family Planning Services (including Diagnosis of Infertility, Genetic Testing, Vasectomy and Termination of Pregnancy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Oral Surgery, TMJ Treatment and	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider	

MEDICAL SERVICES				
Medical Service	**Tier 1 Providers** **Member Financial Responsibility**	**Tier 2 Providers** **Member Financial Responsibility**	**Out-of-Network: All Other Hospitals and Physicians** **Member Financial Responsibility**	**Limitations and Special Conditions** **Refer to your Health Benefits booklet for Preauthorization Requirements**
Orthognathic Surgery			Balance Bill	
Pain Management	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
End Stage Renal Disease (Physician and Facility Services)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Approved Clinical Trials	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	Member Cost Sharing applicable to Routine Patient Costs outside of Approved Clinical Trial	
Cancer Drug Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
NICU	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Burn	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
High Risk OB	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	
Applied Behavior Analysis (ABA) Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	40% Coinsurance after Deductible Plus Provider Balance Bill	

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Tier 1 (Preferred Generic)	NA*	$10 Copayment[2] No Deductible	$10 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 2 (Preferred Brand)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - $10 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $30 Copayment[2] No Deductible	$30 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 3 (Non-Preferred Generic, Non-Preferred Brand Drugs)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Non-Preferred Generics - NA* Non-Preferred Brand - $15 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $50 Copayment[2] No Deductible	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Tier 3 (Non-Preferred Generic, Non-Preferred Brand Drugs)	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Non-Preferred Generics - NA* Non-Preferred Brand - $15 Copayment[6] No Deductible	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[2, 5] All other - $50 Copayment[2] No Deductible	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Tier 3 Specialty Drugs	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[4, 5] All other - $5 Copayment No Deductible[4]	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[4, 5] All other - $50 Copayment No Deductible [4]	$50 Copayment Plus 25% of Reimbursement Amount Paid by Plan No Deductible
Preventive Drugs	NA*	$0[2] No Deductible	25% of Reimbursement Amount Paid by Plan No Deductible

PHARMACY BENEFITS			
Drug	**Karmanos Specialty Pharmacy Member Financial Responsibility**	**Preferred Pharmacies Member Financial Responsibility**	**Non-Preferred Pharmacies Member Financial Responsibility**
Mail Order Drugs	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5, 6] All other - Preferred Generic - NA* Non-Preferred Generic - NA* Preferred Brand - $10 Copayment for 3-month supply[6] No Deductible Non-Preferred Brand - $15 Copayment for 3-month supply[6] No Deductible Preventive – NA*	If obtained through the PBM's variable copayment program - Variable Copayment subject to the maximum of any available manufacturer-funded copay assistance program[5] All other - Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand Name Drugs and Preventive Drugs) - One Copayment (as applicable) for a 3-month supply[3] No Deductible	One Copayment (as applicable) for a 3-month supply[3] Plus 25% of Reimbursement Amount Paid by Plan No Deductible

NOTE: For a complete description of benefits, further limitations, conditions, and exclusions, also refer to the Health Benefits booklet. Benefits are subject to change or revision without notice, and this form is not a guarantee of past or future benefits. For McLaren Health Advantage, "covered" out-of-network services means that the services are payable at McLaren Health Advantage's reimbursement amount, less any applicable deductible, coinsurance and/or copayment required by the plan. If you choose to see an out-of-network provider, you may be responsible for any "Balance Billed" monetary difference between McLaren Health Advantage's reimbursement amount and the non-contracted, out-of-network provider's billed charges. Balance Billing can occur when receiving care from a non-contracted, out-of-network provider.

*NA = Not Available

[2] A 3-month supply of Tier 1, Tier 2, Tier 3 non-preferred generic and non-preferred brand and preventive drugs may be obtained from a retail pharmacy if a

member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment for Tier 1 drugs, and three copayments for Tier 2 and Tier 3 non-preferred generic and non-preferred brand drugs.

[3] A 3-month supply of Tier 1, Tier 2, Tier 3 non-preferred generic and non-preferred brand drugs and preventive brand drugs may be obtained through mail order if a member successfully completes a thirty (30) day trial of the drug. A 3-month supply may be obtained with one copayment for Preferred Pharmacies. A 3-month supply may be obtained with one copayment plus 25% of Reimbursement Amount paid by plan for Non-Preferred Pharmacies.

[4] Limited to up to a 30-day supply.

[5] However, in no case will true out-of-pocket costs to the Member be greater than the Copayment specified for the drug above (e.g., $50