MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO MCLAREN REWARDS - GOLD
SCHEDULE OF COST SHARING

"Rewards Providers" are a subset of MHP Community Participating Providers. When you receive services from Rewards Providers, your standard Copayments, Coinsurance and Deductible may be reduced or eliminated. Please review the detailed chart below for information specific to each Covered Service. "Rewards Providers" are identified in the MHP Community Provider Directory.

Deductible	Out-of-Pocket Maximum
$3,500 Individual $7,000 Family	$8,150 Individual $16,300 Family

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Preventive Services	$0	$0	100% - No Coverage
Diabetic Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$40 Copayment No Deductible	$0	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	$60 Copayment No Deductible	$0	100% - No Coverage
Allergy Testing (Non-Injections)	25% Coinsurance and Deductible	$0	100% - No Coverage
Allergy Injections	$0	$0	100% - No Coverage
Immunizations (other than Preventive Care)	25% Coinsurance and Deductible	$0	100% - No Coverage
Maternity Care	Prenatal Office Visits - $0 All other Maternity Care – 25% Coinsurance and Deductible	$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	25% Coinsurance and Deductible	$0	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Emergency Care – Emergency Room	$100 Copayment After Deductible (Copayment waived if admitted to Hospital)	$0	$100 Copayment After Deductible (Copayment waived if admitted to Hospital) plus Balance Billing
Urgent Care	$60 Copayment No Deductible	$0	$60 Copayment plus Balance Billing No Deductible
Ambulance	25% Coinsurance and Deductible	$0	25% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Hospital Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	25% Coinsurance and Deductible	$0	100% - No Coverage
Organ and Tissue Transplants	25% Coinsurance and Deductible	$0	100% - No Coverage
Special Surgical Procedures	25% Coinsurance and Deductible	$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	25% Coinsurance and Deductible	$0	100% - No Coverage
Skilled Nursing Facility Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Home Care Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Hospice Care	25% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Mental Health Services	$40 Copayment No Deductible	$0	100% - No Coverage
Inpatient Mental Health Services	25% Coinsurance and Deductible	$0	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Emergency Mental Health Services	$100 Copayment After Deductible (Copayment waived if admitted to Hospital)	$0	$100 Copayment After Deductible (Copayment waived if admitted to Hospital) plus Balance Billing
Outpatient Substance Abuse Services	$40 Copayment No Deductible	$0	100% - No Coverage
Inpatient Substance Abuse Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Emergency Substance Abuse Services	$100 Copayment After Deductible (Copayment waived if admitted to Hospital)	$0	$100 Copayment After Deductible (Copayment waived if admitted to Hospital) plus Balance Billing
Outpatient Habilitative Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Rehabilitation	25% Coinsurance and Deductible	$0	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	25% Coinsurance and Deductible	$0	100% - No Coverage
Reproductive Care and Family Planning Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Pediatric Vision	25% Coinsurance and Deductible	$0	100% - No Coverage
Oral Surgery	25% Coinsurance and Deductible	$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Orthognathic Surgery	25% Coinsurance and Deductible	$0	100% - No Coverage
Pain Management	25% Coinsurance and Deductible	$0	100% - No Coverage
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	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Cancer Drug Therapy	25% Coinsurance and Deductible	$0	100% - No Coverage
Educational Services	25% Coinsurance and Deductible	$0	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. $40 Copayment; No Deductible b. 25% Coinsurance and Deductible	$0	100% - No Coverage
Vision Exam (Adult)	25% Coinsurance and Deductible	$0	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	$30 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$50 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	$125 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	$275 Copayment No Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage