MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO MCLAREN REWARDS – PLATINUM 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	
\$500 Individual	\$3,000 Individual	
\$1,000 Family	\$6,000 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	20% Coinsurance and Deductible	\$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	\$30 Copayment No Deductible	\$0	100% - No Coverage
Specialist Office Visit (other than Allergy Testing and Allergy Injections)	\$40 Copayment No Deductible	\$0	100% - No Coverage
Allergy Testing (Non- Injections)	20% Coinsurance and Deductible	\$0	100% - No Coverage
Allergy Injections	\$0	\$0	100% - No Coverage
Immunizations (other than Preventive Care)	20% Coinsurance and Deductible	\$0	100% - No Coverage
Maternity Care	Prenatal Office Visits - \$0 All other Maternity Care – 20% Coinsurance and Deductible	\$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	20% Coinsurance and Deductible	\$0	100% - No Coverage

Benefit	In-Network Member	Rewards Network	Out-of-Network
	Financial	Member Financial	Member Financial
	Responsibility	Responsibility	Responsibility
Emergency Care –	\$250 Copayment	\$0	\$250 Copayment
Emergency Room	(waived if admitted		(waived if admitted
	to Hospital)		to Hospital) plus
	No Deductible		Balance Billing
			No Deductible
Urgent Care	\$60 Copayment	\$0	\$60 Copayment
	No Deductible		plus Balance Billing
			No Deductible
Ambulance	20% Coinsurance and	\$0	20% Coinsurance and
	Deductible		Deductible plus
			Balance Billing
Inpatient Hospital	20% Coinsurance and	\$0	100% - No Coverage
Services	Deductible		
Outpatient Hospital	20% Coinsurance and	\$0	100% - No Coverage
Services	Deductible		
Diagnostic and	20% Coinsurance and	\$0	100% - No Coverage
Therapeutic Services	Deductible		
and Tests (other than			
Preventive Services)	200/ Cainavenas and	Ć0	1000/ No Coverso
Organ and Tissue	20% Coinsurance and Deductible	\$0	100% - No Coverage
Transplants Special Surgical	20% Coinsurance and	\$0	100% - No Coverage
Procedures	Deductible	ŞU	100% - NO Coverage
Frocedures	Deddelible		
Breast Reconstruction	20% Coinsurance and	\$0	100% - No Coverage
Following Mastectomy	Deductible		
Skilled Nursing Facility	20% Coinsurance and	\$0	100% - No Coverage
Services	Deductible		
Home Care Services	20% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Hospice Care	20% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Outpatient Mental	\$30 Copayment	\$0	100% - No Coverage
Health Services	No Deductible		
Inpatient Mental	20% Coinsurance and	\$0	100% - No Coverage
Health Services	Deductible		

Benefit	In-Network Member	Rewards Network	Out-of-Network
	Financial	Member Financial	Member Financial
	Responsibility	Responsibility	Responsibility
Emergency Mental	\$250 Copayment	\$0	\$250 Copayment
Health Services	(waived if admitted to		(waived if admitted
	Hospital)		to Hospital) plus
	No Deductible		Balance Billing
	4	4.5	No Deductible
Outpatient Substance	\$30 Copayment	\$0	100% - No Coverage
Abuse Services	No Deductible	40	1000/ 11 0
Inpatient Substance	20% Coinsurance and	\$0	100% - No Coverage
Abuse Services	Deductible	4.5	1
Emergency Substance	\$250 Copayment	\$0	\$250 Copayment
Abuse Services	(waived if admitted to		(waived if admitted
	Hospital) No Deductible		to Hospital) plus
	No Deductible		Balance Billing No Deductible
Outpatient Habilitative	20% Coinsurance and	\$0	100% - No Coverage
Services	Deductible	γo	100% No coverage
Outpatient	20% Coinsurance and	\$0	100% - No Coverage
Rehabilitation	Deductible	70	100/0 110 60161466
Durable Medical	20% Coinsurance and	\$0	100% - No Coverage
Equipment (DME) and	Deductible	, -	
Supplies			
Reproductive Care and	20% Coinsurance and	\$0	100% - No Coverage
Family Planning	Deductible		
Services			
Pediatric Vision	20% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Oral Surgery	20% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Temporomandibular	20% Coinsurance and	\$0	100% - No Coverage
Joint Syndrome (TMJ)	Deductible		
Services			
Orthognathic Surgery	20% Coinsurance and	\$0	100% - No Coverage
	Deductible	4-	
Pain Management	20% Coinsurance and	\$0	100% - No Coverage
A	Deductible	Marshar C. J.Cl. J.	4000/ N - C
Approved Clinical Trials	Member Cost Sharing	Member Cost Sharing	100% - No Coverage
	applicable to Routine	applicable to Routine	
	Patient Costs outside of	Patient Costs outside of	
	Approved Clinical Trial	Approved Clinical Trial	

Benefit	In-Network Member Financial	Rewards Network Member Financial	Out-of-Network Member Financial
	Responsibility	Responsibility	Responsibility
Cancer Drug Therapy	20% Coinsurance and Deductible	\$0	100% - No Coverage
Educational Services	20% Coinsurance and Deductible	\$0	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. \$30 Copayment; No Deductible b. 20% Coinsurance and Deductible	\$0	100% - No Coverage
Vision Exam (Adult)	20% Coinsurance and Deductible	\$0	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	\$20 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	\$45 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	\$75 Copayment No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	\$250 Copayment No Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage