MCLAREN HEALTH PLAN COMMUNITY

INDIVIDUAL HMO MCLAREN REWARDS – SILVER 94%
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 $1,000 Family	$850 Individual $1,700 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	No charge after Deductible	$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	No charge after Deductible	$0	100% - No Coverage
Specialist Office Visit	No charge after Deductible	$0	100% - No Coverage
Immunizations (other than Preventive Care)	No charge after Deductible	$0	100% - No Coverage
Maternity Care	Prenatal Office Visits - $0 All other Maternity Care – No charge after Deductible	$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	No charge after Deductible	$0	100% - No Coverage
Emergency Care – Emergency Room	No charge after Deductible	$0	No charge after Deductible
Urgent Care	No charge after Deductible	$0	No charge after Deductible plus Balance Billing
Ground Ambulance	No charge after Deductible	$0	No charge after Deductible plus Balance Billing

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Air Ambulance	No charge after Deductible	$0	No charge after Deductible
Inpatient Hospital Services	No charge after Deductible	$0	100% - No Coverage
Outpatient Hospital Services	No charge after Deductible	$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	No charge after Deductible	$0	100% - No Coverage
Organ and Tissue Transplants	No charge after Deductible	$0	100% - No Coverage
Special Surgical Procedures	No charge after Deductible	$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	No charge after Deductible	$0	100% - No Coverage
Skilled Nursing Facility Services	No charge after Deductible	$0	100% - No Coverage
Home Care Services	No charge after Deductible	$0	100% - No Coverage
Hospice Care	No charge after Deductible	$0	100% - No Coverage
Outpatient Mental Health Services	No charge after Deductible	$0	100% - No Coverage
Inpatient Mental Health Services	No charge after Deductible	$0	100% - No Coverage
Emergency Mental Health Services	No charge after Deductible	$0	No charge after Deductible
Outpatient Substance Abuse Services	No charge after Deductible	$0	100% - No Coverage
Inpatient Substance Abuse Services	No charge after Deductible	$0	100% - No Coverage
Emergency Substance Abuse Services	No charge after Deductible	$0	No charge after Deductible
Outpatient Habilitative Services	No charge after Deductible	$0	100% - No Coverage
Outpatient Rehabilitation	No charge after Deductible	$0	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Durable Medical Equipment (DME) and Supplies	No charge after Deductible	$0	100% - No Coverage
Reproductive Care and Family Planning Services	No charge after Deductible	$0	100% - No Coverage
Pediatric Vision	No charge after Deductible	$0	100% - No Coverage
Oral Surgery	No charge after Deductible	$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	No charge after Deductible	$0	100% - No Coverage
Orthognathic Surgery	No charge after Deductible	$0	100% - No Coverage
Pain Management	No charge after 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
Cancer Drug Therapy	No charge after Deductible	$0	100% - No Coverage
Educational Services	No charge after Deductible	$0	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. No charge after Deductible b. No charge after Deductible	$0	100% - No Coverage
Vision Exam (Adult)	No charge after Deductible	$0	100% - No Coverage

Pharmacy	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	$2 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$15 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	25% Coinsurance	100% - No Coverage
Tier 4 (Specialty Drugs)	25% Coinsurance	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage