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
\$4,000 Individual	\$8,150 Individual
\$8,000 Family	\$16,300 Family

Benefit	In-Network Member Financial	Rewards Network Member Financial	Out-of-Network Member Financial
Droventive Conviews	Responsibility	Responsibility	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	\$75 Copayment	\$0	100% - No Coverage
(other than Allergy	No Deductible	Ţ -	
Testing and Allergy			
Injections)			
Allergy Testing (Non-	25% Coinsurance and	\$0	100% - No Coverage
Injections)	Deductible		
Allergy Injections	\$0	\$0	100% - No Coverage
Immunizations (other	25% Coinsurance and	\$0	100% - No Coverage
than Preventive Care)	Deductible		
Maternity Care	Prenatal Office Visits -	\$0	100% - No Coverage
	\$0		
	All other Maternity		
	Care – 25%		
	Coinsurance and		
	Deductible		
Injectable Drugs	25% Coinsurance and	\$0	100% - No Coverage
Provided in the	Deductible		
Physician Office			

Benefit	In-Network Member	Rewards Network	Out-of-Network
	Financial	Member Financial	Member Financial
	Responsibility	Responsibility	Responsibility
Emergency Care –	\$100 Copayment After	\$0	\$100 Copayment After
Emergency Room	Deductible		Deductible (Copayment
	(Copayment waived if		waived if admitted
	admitted		to Hospital)
	to Hospital)		
Urgent Care	\$60 Copayment	\$0	\$60 Copayment
	No Deductible		plus Balance Billing
		4.0	No Deductible
Ground Ambulance	25% Coinsurance and	\$0	25% Coinsurance and
	Deductible		Deductible plus
		40	Balance Billing
Air Ambulance	25% Coinsurance and	\$0	25% Coinsurance and
	Deductible	<u> </u>	Deductible
Inpatient Hospital	25% Coinsurance and	\$0	100% - No Coverage
Services	Deductible	<u> </u>	
Outpatient Hospital Services	25% Coinsurance and Deductible	\$0	100% - No Coverage
		\$0	
Diagnostic and Therapeutic Services	25% Coinsurance and Deductible	ŞU	100% - No Coverage
and Tests (other than	Deductible		
Preventive Services)			
Organ and Tissue	25% Coinsurance and	\$0	100% - No Coverage
Transplants	Deductible	ŲŲ	100% NO COVERAGE
Special Surgical	25% Coinsurance and	\$0	100% - No Coverage
Procedures	Deductible	ΨŪ	100% No coverage
	Deddottore		
Breast Reconstruction	25% Coinsurance and	\$0	100% - No Coverage
Following Mastectomy	Deductible	+ -	
Skilled Nursing Facility	25% Coinsurance and	\$0	100% - No Coverage
Services	Deductible	·	Ŭ
Home Care Services	25% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Hospice Care	25% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Outpatient Mental	\$40 Copayment	\$0	100% - No Coverage
Health Services	No Deductible		
Inpatient Mental	25% Coinsurance and	\$0	100% - No Coverage
Health Services	Deductible		

Benefit	In-Network Member	Rewards Network	Out-of-Network
	Financial Responsibility	Member Financial Responsibility	Member Financial Responsibility
	Responsibility	Responsibility	Responsibility
Emergency Mental	\$100 Copayment After	\$0	\$100 Copayment After
Health Services	Deductible (Copayment		Deductible (Copayment
	waived if admitted to		waived if admitted
	Hospital)		to Hospital)
Outpatient Substance	\$40 Copayment	\$0	100% - No Coverage
Abuse Services	No Deductible		
Inpatient Substance	25% Coinsurance and	\$0	100% - No Coverage
Abuse Services	Deductible		
Emergency Substance	\$100 Copayment After	\$0	\$100 Copayment After
Abuse Services	Deductible		Deductible (Copayment
	(Copayment waived if		waived if admitted
	admitted to Hospital)		to Hospital)
Outpatient Habilitative	25% Coinsurance and	\$0	100% - No Coverage
Services	Deductible		
Outpatient	25% Coinsurance and	\$0	100% - No Coverage
Rehabilitation	Deductible		
Durable Medical	25% Coinsurance and	\$0	100% - No Coverage
Equipment (DME) and	Deductible		
Supplies			
Reproductive Care and	25% Coinsurance and	\$0	100% - No Coverage
Family Planning	Deductible		
Services			
Pediatric Vision	25% Coinsurance and	\$0	100% - No Coverage
	Deductible		
Oral Surgery	25% Coinsurance and	\$0	100% - No Coverage
	Deductible	4.0	
Temporomandibular	25% Coinsurance and	\$0	100% - No Coverage
Joint Syndrome (TMJ)	Deductible		
Services		4.0	
Orthognathic Surgery	25% Coinsurance and	\$0	100% - No Coverage
	Deductible	<u> </u>	1000/ 11 0
Pain Management	25% Coinsurance and Deductible	\$0	100% - No Coverage
Approved Clinical Trials	Member Cost Sharing	Member Cost Sharing	
	applicable to Routine	applicable to Routine	100% - No Coverage
	Patient Costs outside of	Patient Costs outside of	
	Approved Clinical Trial	Approved Clinical Trial	
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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