MCLAREN HEALTH PLAN COMMUNITY

SMALL GROUP HMO MCLAREN REWARDS – PLATINUM 1250
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
$1,250 Individual $2,500 Family	$5,000 Individual $10,000 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 Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Emergency Care – Emergency Room	$250 Copayment (waived if admitted to Hospital) No Deductible	$0	$250 Copayment (waived if admitted to Hospital) No Deductible
Urgent Care	$60 Copayment No Deductible	$0	$60 Copayment plus Balance Billing No Deductible
Ground Ambulance	20% Coinsurance and Deductible	$0	20% Coinsurance and Deductible plus Balance Billing
Air Ambulance	20% Coinsurance and Deductible	$0	20% Coinsurance and Deductible
Inpatient Hospital Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Hospital Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	20% Coinsurance and Deductible	$0	100% - No Coverage
Organ and Tissue Transplants	20% Coinsurance and Deductible	$0	100% - No Coverage
Special Surgical Procedures	20% Coinsurance and Deductible	$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	20% Coinsurance and Deductible	$0	100% - No Coverage
Skilled Nursing Facility Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Home Care Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Hospice Care	20% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Mental Health Services	$30 Copayment No Deductible	$0	100% - No Coverage
Inpatient Mental Health Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Emergency Mental Health Services	$250 Copayment (waived if admitted to	$0	$250 Copayment (waived if admitted

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
	Hospital) No Deductible		to Hospital) No Deductible
Outpatient Substance Abuse Services	$30 Copayment No Deductible	$0	100% - No Coverage
Inpatient Substance Abuse Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Emergency Substance Abuse Services	$250 Copayment (waived if admitted to Hospital) No Deductible	$0	$250 Copayment (waived if admitted to Hospital) No Deductible
Outpatient Habilitative Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Rehabilitation	20% Coinsurance and Deductible	$0	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	20% Coinsurance and Deductible	$0	100% - No Coverage
Reproductive Care and Family Planning Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Pediatric Vision	20% Coinsurance and Deductible	$0	100% - No Coverage
Oral Surgery	20% Coinsurance and Deductible	$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	20% Coinsurance and Deductible	$0	100% - No Coverage
Orthognathic Surgery	20% Coinsurance and Deductible	$0	100% - No Coverage
Pain Management	20% 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
Cancer Drug Therapy	20% Coinsurance and Deductible	$0	100% - No Coverage
Educational Services	20% Coinsurance and Deductible	$0	100% - No Coverage

Benefit	In-Network Member Financial Responsibility	Rewards Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
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