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) |
| | No Deductible | | No Deductible |
| Urgent Care | \$60 Copayment | \$0 | \$60 Copayment |
| | No Deductible | | plus Balance Billing |
| | | | No Deductible |
| Ground Ambulance | 20% Coinsurance and | \$0 | 20% Coinsurance and |
| | Deductible | | Deductible plus |
| | | | Balance Billing |
| Air Ambulance | 20% Coinsurance and | \$0 | 20% Coinsurance and |
| | Deductible | | Deductible |
| 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) | | | |
| Organ and Tissue | 20% Coinsurance and | \$0 | 100% - No Coverage |
| Transplants | Deductible | | |
| Special Surgical | 20% Coinsurance and | \$0 | 100% - No Coverage |
| Procedures | Deductible | | |
| 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 | | |
| Emergency Mental | \$250 Copayment | \$0 | \$250 Copayment |
| Health Services | (waived if admitted to | | (waived if admitted |

| Benefit In-Network Member Financial Member Financial Responsibility Hospital) No Deductible Outpatient Substance \$30 Copayment \$0 No Deductible Inpatient Substance 20% Coinsurance and \$0 Abuse Services Deductible Emergency Substance \$250 Copayment \$0 Abuse Services (waived if admitted to Hospital) No Deductible Outpatient Habilitative 20% Coinsurance and \$0 Deductible Outpatient Habilitative 20% Coinsurance and \$0 Deductible Outpatient 20% Coinsurance and \$0 Deductible Durable Medical 20% Coinsurance and \$0 Deductible Supplies Deductible Deductible Outpatient 20% Coinsurance and \$0 Deductible | cial Member Financial |
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| Responsibility Hospital) No Deductible Outpatient Substance Abuse Services Inpatient Substance Abuse Services Deductible Emergency Substance Abuse Services (waived if admitted to Hospital) No Deductible Outpatient Habilitative Services Deductible Outpatient Habilitative Services Deductible Outpatient Deductible Outpatient Deductible Outpatient Deductible Outpatient Deductible Outpatient Deductible Durable Medical Equipment (DME) and Supplies | y Responsibility to Hospital) No Deductible 100% - No Coverage 100% - No Coverage \$250 Copayment (waived if admitted to Hospital) No Deductible |
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| Outpatient Habilitative Services Deductible Outpatient 20% Coinsurance and \$0 Rehabilitation Deductible Durable Medical 20% Coinsurance and \$0 Equipment (DME) and Supplies | |
| Services Outpatient Rehabilitation Durable Medical Equipment (DME) and Supplies Deductible 20% Coinsurance and Deductible 20% Coinsurance and Deductible | 100% - No Coverage |
| Outpatient 20% Coinsurance and \$0 Rehabilitation Deductible Durable Medical 20% Coinsurance and \$0 Equipment (DME) and Deductible Supplies | 10070 IND COVETAGE |
| Rehabilitation Deductible Durable Medical 20% Coinsurance and 50 Equipment (DME) and Deductible Supplies | |
| Durable Medical 20% Coinsurance and \$0 Equipment (DME) and Deductible Supplies | 100% - No Coverage |
| Equipment (DME) and Deductible Supplies | |
| Supplies | 100% - No Coverage |
| | |
| | |
| 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 | 1000/ 11 0 |
| Temporomandibular 20% Coinsurance and \$0 | 100% - No Coverage |
| Joint Syndrome (TMJ) Deductible | |
| Services 20% Colinary and CO | 1000/ No Coversor |
| Orthognathic Surgery 20% Coinsurance and \$0 Deductible | 100% - No Coverage |
| | 100% No Coverage |
| Pain Management 20% Coinsurance and \$0 Deductible | 100% - No Coverage |
| Approved Clinical Trials Member Cost Sharing Member Cost Sha | oring 100% No Coverage |
| j | |
| applicable to Routine applicable to Rou Patient Costs outside of Patient Costs outsi | |
| Approved Clinical Trial Approved Clinical | |
| Cancer Drug Therapy 20% Coinsurance and \$0 | TITUI |
| Deductible | 100% - No Coverage |
| Educational Services 20% Coinsurance and \$0 | 100% - No Coverage |
| Deductible | 100% - No Coverage 100% - No Coverage |

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

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