MCLAREN HEALTH PLAN COMMUNITY

MCLAREN REWARDS HMO - PLATINUM

SCHEDULE OF COPAYMENTS AND DEDUCTIBLES

"**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	$2,000 Individual $4,000 Family		
Medical Service	**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	10% Coinsurance and Deductible	$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$25 Copayment No Deductible	$0	100% - No Coverage
Specialist Office Visit	$50 Copayment No Deductible	$0	100% - No Coverage
Immunizations (other than Preventive Care)	10% Coinsurance and Deductible	$0	100% - No Coverage
Maternity Care	Prenatal Office Visits – $0 All other Maternity Care – 10% Coinsurance and Deductible	$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	10% Coinsurance and Deductible	$0	100% - No Coverage
Spinal Treatment	10% Coinsurance and Deductible	$0	100% - No Coverage

Emergency Care – Emergency Room	$250 Copayment (waived if admitted to Hospital) No Deductible	$0	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Urgent Care	$60 Copayment No Deductible	$0	$60 Copayment plus Balance Billing No Deductible
Ambulance	10% Coinsurance and Deductible	$0	10% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	10% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Hospital Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	10% Coinsurance and Deductible	$0	100% - No Coverage
Organ and Tissue Transplants	10% Coinsurance and Deductible	$0	100% - No Coverage
Special Surgical Procedures	10% Coinsurance and Deductible	$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	10% Coinsurance and Deductible	$0	100% - No Coverage
Skilled Nursing Facility Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Home Care Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Hospice Care	10% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Mental Health Services	$25 Copayment No Deductible	$0	100% - No Coverage
Inpatient Mental Health Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Emergency Mental Health Services	$250 (waived if admitted to Hospital) No Deductible	$0	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Substance Abuse Services	$25 Copayment No Deductible	$0	100% - No Coverage
Inpatient Substance Abuse Services	10% Coinsurance and Deductible	$0	100% - No Coverage

Emergency Substance Abuse Services	$250 (waived if admitted to Hospital) No Deductible	$0	$250 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Habilitative Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Outpatient Rehabilitation	10% Coinsurance and Deductible	$0	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	10% Coinsurance and Deductible	$0	100% - No Coverage
Reproductive Care and Family Planning Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Pediatric Vision	10% Coinsurance and Deductible	$0	100% - No Coverage
Oral Surgery	10% Coinsurance and Deductible	$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Orthognathic Surgery	10% Coinsurance and Deductible	$0	100% - No Coverage
Pain Management	10% 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	10% Coinsurance and Deductible	$0	100% - No Coverage
Educational Services	10% Coinsurance and Deductible	$0	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. $25 Copayment; No Deductible b. 10% Coinsurance and Deductible	$0	100% - No Coverage

Pharmacy	Member Financial Responsibility	Out-of-Network
Tier 1	$5 Copayment No Deductible	100% - No Coverage
Tier 2	$30 Copayment No Deductible	100% - No Coverage
Tier 3	$200 Copayment No Deductible	100% - No Coverage
Specialty Drugs	$300 Copayment No Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage