

MCLAREN HEALTH PLAN COMMUNITY

MCLAREN REWARDS - SILVER

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		
\$6,000 Individual \$12,000 Family	\$7,350 Individual \$14,700 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	30% Coinsurance and Deductible	\$0	100% - No Coverage
Primary Care Physician (PCP) Office Visits	30% Coinsurance and Deductible	\$0	100% - No Coverage
Specialist Office Visit	30% Coinsurance and Deductible	\$0	100% - No Coverage
Immunizations (other than Preventive Care)	30% Coinsurance and Deductible	\$0	100% - No Coverage
Maternity Care	Prenatal Office Visits – \$0 All other Maternity Care – 30% Coinsurance and Deductible	\$0	100% - No Coverage
Injectable Drugs Provided in the Physician Office	30% Coinsurance and Deductible	\$0	100% - No Coverage
Spinal Treatment	30% Coinsurance and Deductible	\$0	100% - No Coverage

Emergency Care – Emergency Room	30% Coinsurance and Deductible	\$0	\$400 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Urgent Care	30% Coinsurance and Deductible	\$0	\$60 Copayment plus Balance Billing No Deductible
Ambulance	30% Coinsurance and Deductible	\$0	25% Coinsurance and Deductible plus Balance Billing
Inpatient Hospital Service	30% Coinsurance and Deductible	\$0	100% - No Coverage
Outpatient Hospital Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	30% Coinsurance and Deductible	\$0	100% - No Coverage
Organ and Tissue Transplants	30% Coinsurance and Deductible	\$0	100% - No Coverage
Special Surgical Procedures	30% Coinsurance and Deductible	\$0	100% - No Coverage
Breast Reconstruction Following Mastectomy	30% Coinsurance and Deductible	\$0	100% - No Coverage
Skilled Nursing Facility Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Home Care Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Hospice Care	30% Coinsurance and Deductible	\$0	100% - No Coverage
Outpatient Mental Health Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Inpatient Mental Health Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Emergency Mental Health Services	30% Coinsurance and Deductible	\$0	\$400 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Substance Abuse Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Inpatient Substance Abuse Services	30% Coinsurance and Deductible	\$0	100% - No Coverage

Emergency Substance Abuse Services	30% Coinsurance and Deductible	\$0	\$400 Copayment (waived if admitted to Hospital) plus Balance Billing No Deductible
Outpatient Habilitative Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Outpatient Rehabilitation	30% Coinsurance and Deductible	\$0	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	30% Coinsurance and Deductible	\$0	100% - No Coverage
Reproductive Care and Family Planning Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Pediatric Vision	30% Coinsurance and Deductible	\$0	100% - No Coverage
Oral Surgery	30% Coinsurance and Deductible	\$0	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Orthognathic Surgery	30% Coinsurance and Deductible	\$0	100% - No Coverage
Pain Management	30% 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	30% Coinsurance and Deductible	\$0	100% - No Coverage
Educational Services	30% Coinsurance and Deductible	\$0	100% - No Coverage
Autism Spectrum Disorder Services a. Outpatient Mental Health b. ABA (Habilitative) Services	a. 30% Coinsurance and Deductible b. 30% Coinsurance and Deductible	\$0	100% - No Coverage

Pharmacy	Member Financial Responsibility	Out-of-Network
Tier 1	\$30 Copayment No Deductible	100% - No Coverage
Tier 2	\$100 Copayment No Deductible	100% - No Coverage
Tier 3	\$250 Copayment No Deductible	100% - No Coverage
Specialty Drugs	\$350 Copayment No Deductible	100% - No Coverage
Preventive Drugs	\$0	100% - No Coverage