# MCLAREN HEALTH PLAN COMMUNITY

## MCLAREN REWARDS 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<br>$1,000 Family | $2,550 Individual<br>$5,1000 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<br>No Deductible | $0 | 100% - No Coverage |
| Specialist Office Visit | $50 Copayment<br>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<br>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 |

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| Emergency Care – Emergency Room | $250 Copayment (waived if admitted to Hospital)<br>No Deductible | $0 | $250 Copayment (waived if admitted to Hospital) plus Balance Billing<br>No Deductible |
| Urgent Care | $60 Copayment<br>No Deductible | $0 | $60 Copayment plus Balance Billing<br>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<br>No Deductible | $0 | 100% - No Coverage |
| Inpatient Mental Health Services | 10% Coinsurance and Deductible | $0 | 100% - No Coverage |
| Emergency Mental Health Services | $250 Copayment (waived if admitted to Hospital)<br>No Deductible | $0 | $250 Copayment (waived if admitted to Hospital) plus Balance Billing<br>No Deductible |
| Outpatient Substance Abuse Services | $25 Copayment<br>No Deductible | $0 | 100% - No Coverage |
| Inpatient Substance Abuse Services | 10% Coinsurance and Deductible | $0 | 100% - No Coverage |

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|---|---|---|---|
| Emergency Substance Abuse Services | $250 Copayment (waived if admitted to Hospital)<br>No Deductible | $0 | $250 Copayment (waived if admitted to Hospital) plus Balance Billing<br>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<br>a. Outpatient Mental Health<br>b. ABA (Habilitative) Services | a. $25 Copayment; No Deductible<br>b. 10% Coinsurance and Deductible | $0 | 100% - No Coverage |

| Pharmacy | In-Network Member Financial Responsibility | Out-of-Network Member Financial Responsibility |
|---|---|---|
| Tier 1 (Preferred Generic) | $5 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 2 (Preferred Brand) | $30 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 3 (Non-Preferred Generic and Non-Preferred Brand) | $200 Copayment<br>No Deductible | 100% - No Coverage |
| Tier 4 (Specialty Drugs) | $300 Copayment<br>No Deductible | 100% - No Coverage |
| Preventive Drugs | $0 | 100% - No Coverage |