MCLAREN HEALTH PLAN COMMUNITY
INDIVIDUAL HMO – MHP SILVER EXCHANGE REWARDS 94%

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.

Rewards Deductible	
Individual	*Family*
$0	$0 per person $0 per group

In-Network Medical Deductible		**Out-of-Network Medical Deductible**	
Individual	*Family*	*Individual*	*Family*
$500	$500 per person $1,000 per group	Not Applicable	Not Applicable

In-Network Pharmacy Deductible		**Out-of-Network Pharmacy Deductible**	
Individual	*Family*	*Individual*	*Family*
$0	$0 per person $0 per group	Not Applicable	Not Applicable

In-Network Out-of-Pocket Maximum		**Out-of-Network Out-of-Pocket Maximum**	
Individual	*Family*	*Individual*	*Family*
$850	$850 per person $1,700 per group	Not Applicable	Not Applicable

Medical Benefit	**Rewards Network Member Financial Responsibility**	**In-Network Member Financial Responsibility**	**Out-of-Network Member Financial Responsibility***
Preventive Services	$0	$0	100% - No Coverage
Diabetic Services and Supplies (other than Diabetes Education)	$0	20% Coinsurance after Deductible	100% - No Coverage
Primary Care Physician (PCP) Office Visits	$0	20% Coinsurance after Deductible	100% - No Coverage
Specialist Office Visit (other than Allergy Injections)	$0	20% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	Rewards Network Member Financial Responsibility	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Allergy Testing (Non-Injections)	$0	20% Coinsurance after Deductible	100% - No Coverage
Allergy Injections	$0	$0	100% - No Coverage
Immunizations (other than Preventive Care)	$0	20% Coinsurance after Deductible	100% - No Coverage
Maternity Care – Preventive Prenatal and Postnatal Office Visits	$0	$0	100% - No Coverage
Maternity Care – All Other Maternity Care	$0	20% Coinsurance after Deductible	100% - No Coverage
Injectable Drugs Provided in the Physician Office	$0	20% Coinsurance after Deductible	100% - No Coverage
Emergency Care – Emergency Room	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Urgent Care	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible plus Balance Billing
Ground Ambulance	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible plus Balance Billing
Air Ambulance	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Inpatient Hospital Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Hospital Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Diagnostic and Therapeutic Services and Tests (other than Preventive Services)	$0	20% Coinsurance after Deductible	100% - No Coverage
Organ and Tissue Transplants	$0	20% Coinsurance after Deductible	100% - No Coverage
Special Surgical Procedures	$0	20% Coinsurance after Deductible	100% - No Coverage
Weight Loss Procedures	$0	20% Coinsurance after Deductible	100% - No Coverage
Breast Reconstruction Following Mastectomy	$0	20% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	Rewards Network Member Financial Responsibility	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Skilled Nursing Facility Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Home Care Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Hospice Care	$0	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Mental Health Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Inpatient Mental Health Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Emergency Mental Health Services	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Substance Abuse Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Inpatient Substance Abuse Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Emergency Substance Abuse Services	$0	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Habilitative Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Outpatient Rehabilitation	$0	20% Coinsurance after Deductible	100% - No Coverage
Durable Medical Equipment (DME) and Supplies	$0	20% Coinsurance after Deductible	100% - No Coverage
Prosthetics, Orthotics and Corrective Appliances	$0	20% Coinsurance after Deductible	100% - No Coverage
Reproductive Care and Family Planning Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Pediatric Vision	$0	$0	100% - No Coverage
Oral Surgery	$0	20% Coinsurance after Deductible	100% - No Coverage
Temporomandibular Joint Syndrome (TMJ) Services	$0	20% Coinsurance after Deductible	100% - No Coverage
Orthognathic Surgery	$0	20% Coinsurance after Deductible	100% - No Coverage

Medical Benefit	Rewards Network Member Financial Responsibility	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility*
Pain Management	$0	20% Coinsurance after Deductible	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	$0	20% Coinsurance after Deductible	100% - No Coverage
Educational and Nutritional Counseling Services	$0	$0	100% - No Coverage
Autism Spectrum Disorder Services - Outpatient Mental Health	$0	20% Coinsurance after Deductible	100% - No Coverage
Autism Spectrum Disorder Services - All other Autism Services (including ABA Services)	$0	20% Coinsurance after Deductible	100% - No Coverage
Vision Exam (Adult)	$0	20% Coinsurance after Deductible	100% - No Coverage

*Note - except for balance billing, Cost-Sharing for Out-of-Network Covered Services applies towards the In-Network Cost-Sharing (e.g., Deductible and Out-of-Pocket Maximum, when applicable).

Pharmacy Benefit	In-Network Member Financial Responsibility	Out-of-Network Member Financial Responsibility
Tier 1 (Preferred Generic)	$2 Copayment No Deductible	100% - No Coverage
Tier 2 (Preferred Brand)	$25 Copayment No Deductible	100% - No Coverage
Tier 3 (Non-Preferred Generic and Non-Preferred Brand)	25% Coinsurance No Deductible	100% - No Coverage
Tier 4 (Specialty Drugs)	25% Coinsurance No Deductible	100% - No Coverage
Preventive Drugs	$0	100% - No Coverage

*Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy.