McLaren HEALTH PLAN COMMUNITY

SUMMARY OF BENEFITS

State of Michigan Plan N072 – N073 Group Number 190053

	Option A Benefit (In-Network)	**Option B Benefit** (Out-of-Network)
	No referrals required for In-Network Specialty consultations* or for the care provided in the In-Network specialist office.	*The member can self-refer to any MHP provider OR choose to see any non-MHP provider for the services listed below. No written referrals are required by the PCP for these services. If the service is noted to be Not Covered, there is no Option B benefit. Provider balance bill may apply.
Deductibles, Copayments and Dollar Maximums		
Plan Year Deductible	$125/$250	$250/$500
Physician Office Copayment	$20 Copay	After Deductible, Covered at 70%
Emergency Room Copayment	$200 Copay (Copayment Waived if Admitted)	$200 Copay
Urgent Care Copayment	$20 Copay	$20 Copay
Outpatient Mental Health Copayment	$20 Copay	After Deductible, Covered at 70%
Special Surgical Procedures Copayment	After Deductible, Covered at 100%	Not Covered
Durable Medical Equipment	Covered at 100%	Not Covered
Prosthetics, Orthotics and Corrective	Covered at 100%	Not Covered
Coinsurance	Covered at 100%	After Deductible, Covered at 80%
Total Out-of-Pocket Maximum	$2,000/$4,000	$2,000/$4,000
Physician Office Visits		
Physician Office Visit	$20 Copay	After Deductible, Covered at 70%
Specialist Office Visit	$20 Copay	After Deductible, Covered at 70%
Preventative and Physician Office Services		
Health Maintenance Exams	Covered at 100%	After Deductible, Covered at 70%
Routine GYN Exams Pap Smears	Covered at 100%	After Deductible, Covered at 70%
Well-Child Care	Covered at 100%	After Deductible, Covered at 70%
Immunizations	Covered at 100%	Not Covered
Pre Natal Care	Covered at 100%	After Deductible, Covered at 70%
Routine Mammogram	Covered at 100%	After Deductible, Covered at 70%
Injections	Covered at 100%	After Deductible, Covered at 70%
Medical Vision Exams	$20 Copay	After Deductible, Covered at 70%
Emergency Care		
Hospital Emergency Room	$200 Copay (Copayment Waived if Admitted)	$200 Copay (Copayment Waived if Admitted)
Urgent Care Center	$20 Copay	$20 Copay
Physician's Office	$20 Copay	After Deductible, Covered at 70%
Ambulance Services – Ground Air (Medically Necessary Only)	After Deductible, Covered at 100%	After Deductible, Covered at 100%
Hospital Services		
In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy; Inhalation Therapy; Hemodialysis; Physical, Speech and Occupational Therapy; Transplant Services; Maternity Care (hospital only); Physician Services Including Consultation	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests	Covered at 100%	After Deductible, Covered at 70%
Diagnostic X-ray, Including Mammography	After Deductible, Covered at 100%	After Deductible, Covered at 70%

*Requires pre-notification or pre-authorization for certain services.

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Special Surgical Procedures		
Bariatric Surgery, Reduction Mammoplasty, Blepharophasty of Upper Eyelids, Panniculectomy, Surgical Treatment of Male Gynecomastia, Procedures to Correct Obstructive Sleep Apnea	After Deductible, Covered at 100% (surgical fees)	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After Deductible, Covered at 100%	Not Covered
Home Health Care	After Deductible, $20 Copay	Not Covered
Hospice Care	After Deductible, Covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
In-Patient Mental Health	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Intermediate Substance Abuse Treatment	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Out-Patient Mental Health	$20 Copay	After Deductible, Covered at 70%
Out-Patient Substance Abuse	$20 Copay	After Deductible, Covered at 70%
Other Services		
Out-Patient Rehabilitation Services – Physical, Occupational and Speech Therapies	$20 Copay Up to Combined Max of 90 Visits Per Year	After Deductible, Covered at 80% Up to Combined Max of 90 Visits Per Year
Chiropractic Spinal Manipulation/Treatment	After Deductible, $20 Copay Up to 24 Visits Per Person, Per Plan Year	Not Covered
Durable Medical Equipment	Covered at 100%	Not Covered
Prosthetics, Orthotics Corrective Appliances	Covered at 100%	Not Covered
Female Voluntary Sterilization and Elective Termination of Pregnancy	Covered at 100%	Not Covered
Infertility Treatment Counseling, Male Voluntary Sterilization	After Deductible, Covered at 100%	Not Covered
Reproductive Care Family Planning Services	$20 Copay	Not Covered
Oral Surgery	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Temporomandibular Joint Syndrome (TMJ) Treatment	After Deductible, Covered at 100% (Surgical Fees)	After Deductible, Covered at 80% (Surgical Fees)
Orthognathic Surgery	After Deductible, Covered at 100% (Surgical Fees)	After Deductible, Covered at 80% (Surgical Fees)
Antineoplastic Drugs	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
PRESCRIPTION DRUG COVERAGE	**RETAIL**	**MAIL ORDER**
Generic	$10 Copay	$20 Copay
Formulary	Brand: $30 Copay Brand Generic Available: $30 Copay Plus Difference in Cost Between Brand and Generic	Brand: $60 Copay Brand Generic Available: $60 Copay Plus Difference in Cost Between Brand and Generic
Non-Formulary**	$60 Copay	$120 Copay

*Requires pre-notification or pre-authorization for certain services. ** Prior authorization or Step Therapy required.

This Summary of Benefits is intended only to highlight the benefits provided by MHP and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the MHP Certificate of Coverage for a complete listing of covered services, limitations and exclusions, and a description of all the terms and conditions of coverage. If this description conflicts in any way with the policy issued to the enrolling group, the policy will prevail. For answers to questions about information that appears in the summary, call Customer Service at (888) 327-0671.