



## HEALTH PLAN

### Summary of Benefits

#### State of Michigan Plan BA02 Effective 10/12/14 Excludes MSPTA T01

Option A Benefit	Option B Benefit
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.

<b>Deductibles, Co-payments and Dollar Maximums</b>		
Plan Year Deductible	\$125/\$250	\$250/\$500
Physician Office Co-Payment	\$20 Copay	After Deductible, Covered at 70%
Emergency Room Co-Payment	\$200 Copay if not Admitted	\$200 Copay if not Admitted
Urgent Care Co-Payment	\$20 Copay	\$20 Copay
Outpatient Mental Health Co-Payment	\$20 Copay	After Deductible, Covered at 70%
Special Surgical Procedures Co-Payment	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	100%	After Deductible, Covered at 80%
Total Out-of-Pocket Maximum	\$2000/\$4000	\$2000/\$4000
<b>Physician Office Visits</b>		
Physician Office Visit	\$20 Copay	After Deductible, Covered at 70%
Specialist Office Visit	\$20 Copay	After Deductible, Covered at 70%
<b>Preventative and Physician Office Services</b>		
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%
Vision Exams	\$20 Copay	After Deductible, Covered at 70%
<b>Emergency Care</b>		
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%
<b>Hospital Services</b>		
<b>In-Patient Hospital Services:</b>		
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%
<b>Out-Patient Hospital Services:</b>		
Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
<b>Diagnostic and Therapeutic Services and Tests</b>		
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%



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<b>Special Surgical Procedures</b>		
Bariatric Surgery, Reduction Mammoplasty, Blepharoplasty of Upper Eyelids, Panniculectomy, Surgical Treatment of Male Gynecomastia, Procedures to Correct Obstructive Sleep Apnea	After Deductible, Covered at 100% (surgical fees)	Not Covered
<b>Alternatives to Hospital Care</b>		
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
<b>Mental Health and Substance Abuse Services</b>		
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%
<b>Other Services</b>		
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	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%
<b>Prescription Drug Coverage</b>		
	<b>Retail</b>	<b>Mail Order</b>
Generic	\$10 Copay	\$20 Copay
	Brand: \$30 Copay	Brand: \$60 Copay
Formulary	Brand Generic Available: \$30 Copay plus difference in cost between Brand and Generic	Brand Generic Available: \$60 Copay plus difference in cost between Brand and Generic
Non-Formulary**	\$60 Copay	\$120 Copay

\*\* Option A requires pre-notification or pre-authorization for most services.

\* Option B requires pre-authorization for certain services. See asterisked items.

\*\* Prior Authorization or Step Therapy Required.



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#### Summary

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.

\*\* Option A requires pre-notification or pre-authorization for most services.

\* Option B requires pre-authorization for certain services. See asterisked items.

\*\* Prior Authorization or Step Therapy Required.