



HEALTH PLAN

**State of Michigan
Plan B334 - For MSPTA (T01)
Summary of Benefits**

| | 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. |
| Deductibles, copayments and Dollar Maximums | | |
| Annual Deductible | None | \$250/\$500 |
| Physician Office copayment | \$10 | After Deductible, Covered at 70% |
| Emergency Room copayment | \$50 | \$50 |
| Urgent Care copayment | \$10 | \$10 |
| Outpatient Mental Health copayment | \$10 | After Deductible, Covered at 70% |
| Special Surgical Procedures copayment | 100% | Not Covered |
| Durable Medical Equipment | 100% | Not Covered |
| Prosthetics, Orthotics and Corrective | 100% | Not Covered |
| Coinsurance | 100% | After Deductible, Covered at 80% |
| Out-of-Pocket Maximum | Not Applicable | \$2000/\$4000 |
| Physician Office Visits | | |
| Physician Office Visits | Covered at 100%, less \$10 copay | After Deductible, Covered at 70% |
| Specialist Office Visit | Covered at 100%, less \$10 copay | After Deductible, Covered at 70% |
| Preventative and Physician Office Services | | |
| Health Maintenance Exams | Covered at 100% | After Deductible, Covered at 70% |
| Routine gynecological exams and pap | 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 and Post 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 | Covered at 100% | Not Covered |
| Emergency Care | | |
| Hospital Emergency Room | Covered at 100%, less \$50 copay (copayment waived if admitted) | Covered at 100%, less \$50 copay (copayment waived if admitted) |
| Urgent Care Center | Covered at 100%, less \$10 copay | Covered at 100%, less \$10 copay |
| Physician's Office | Covered at 100%, less \$10 copay | After Deductible, Covered at 70% |
| Ambulance Services – Ground and Air (Medically Necessary Only) | Covered at 100% | Covered at 100% |
| Hospital Services | | |
| <i>Inpatient Hospital Services</i> Semi-private Room; Surgery and Related Services; Anesthesia, Laboratory and Radiology; Chemotherapy, Inhalation Therapy; Hemodialysis; Physical, Speech and Occupational Therapy; Transplant Services; Maternity Care (hospital only); Physician Services Including Consultation | Covered at 100% | *After Deductible, Covered at 80% |
| <i>Outpatient Hospital Services</i> Outpatient Surgery, Outpatient CT scans, PET scans, MRI and Nuclear Medicine | 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 | Covered at 100% | After Deductible, Covered at 70% |

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

** Call Customer Service at (888) 327-0671 for referral exceptions.

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|--|---|
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| | | |
|------------------------------------|--|--|
| Special Surgical Procedures | | |
|------------------------------------|--|--|

| | | |
|--|---------------------------------|-------------|
| Bariatric Surgery, Reduction Mammoplasty, Blepharoplasty of Upper Eyelids, Panniculectomy, Surgical Treatment of Male Gynecomastia Procedures to Correct Obstructive Sleep Apnea | Covered at 100% (surgical fees) | Not Covered |
|--|---------------------------------|-------------|

| | | |
|--------------------------------------|--|--|
| Alternatives to Hospital Care | | |
|--------------------------------------|--|--|

| | | |
|----------------------|---|-------------|
| Skilled Nursing Care | Covered at 100% | Not Covered |
| Home Health Care | Covered at 100% Up to 60 days per episode per year | Not Covered |
| Hospice Care | Covered at 100% | Not Covered |

| | | |
|---|--|--|
| Mental Health and Substance Abuse Services | | |
|---|--|--|

| | | |
|--|----------------------------------|----------------------------------|
| Inpatient Mental Health | Covered at 100% | After Deductible, Covered at 80% |
| Intermediate Substance Abuse Treatment | Covered at 100% | After Deductible, Covered at 80% |
| Outpatient Mental Health | Covered at 100%, less \$10 copay | After Deductible, Covered at 70% |
| Outpatient Substance Abuse Services | Covered at 100%, less \$10 copay | After Deductible, Covered at 70% |

| | | |
|-----------------------|--|--|
| Other Services | | |
|-----------------------|--|--|

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|--|---|---|
| Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies | Covered at 100% Up to 60 visits per condition per year | *After Deductible, Covered at 80% Up to 60 visits per condition per year |
| Chiropractic Spinal Manipulation/Treatment | Covered at 100% Up to \$1500 per person per year | Covered at 100% Up to \$1500 per person per year |
| Durable Medical Equipment | Covered at 100% | Not Covered |
| Prosthetics, Orthotics and Corrective | Covered at 100% | Not Covered |
| Infertility Treatment and Counseling, Sterilization, and Termination | Covered at 100% | Not Covered |
| Reproductive Care and Family Planning | Covered at 100%, less \$10 copay | Not Covered |
| Oral Surgery | Covered at 100% | *After Deductible, Covered at 80% |
| Temporomandibular Joint Syndrome (TMJ) Treatment | Covered at 100% (Surgical Fees) | *After Deductible, Covered at 80% (Surgical Fees) |
| Orthognathic Surgery | Covered at 100% (Surgical Fees) | *After Deductible, Covered at 80% (Surgical Fees) |
| Antineoplastic Drugs | Covered at 100% | *After Deductible, Covered at 80% |

| Prescription Drug Coverage | Retail | Mail Order |
|----------------------------|-------------------------|-------------------------|
| Generic | Covered with \$5 copay | Covered with \$10 copay |
| Brand | Covered with \$10 copay | Covered with \$20 copay |
| Contraceptives | Included | Included |

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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.