McLaren HEALTH PLAN COMMUNITY

WAVERLY COMMUNITY SCHOOLS C1

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, Co-payments and Dollar Maximums		
Annual Deductible	$250/$500	$1000/$2000
Physician Office Co-payment	$10	After deductible, Covered at 70%
Emergency Room Co-payment	$50	$50
Urgent Care Co-payment	$25	$25
Outpatient Mental Health Co-payment	$10	After deductible, Covered at 70%
Special Surgical Procedures	After deductible 50%	Not Covered
Durable Medical Equipment	After deductible 100%	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 100%	Not Covered
Coinsurance	After deductible 100%	After deductible 80%
Coinsurance Out-of-Pocket Maximum	None	$2500/$5000
Total Out-of-Pocket Maximum	$6350/$12700	$6350/$12700
Physician Office Visits		
Physician Office Visits	Covered at 100%, less $10 co-pay	After deductible, Covered at 70%
Specialist Office Visit	Covered at 100%, less $10 co-pay	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 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 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%, less $10 co-pay	After deductible, Covered at 70%
Emergency Care		
Hospital Emergency Room	Covered at 100%, less $50 co-pay (Co-payment waived if admitted)	Covered at 100%, less $50 co-pay (Co-payment waived if admitted)
Urgent Care Center	Covered at 100%, less $25 co-pay	Covered at 100%, less $25 co-pay
Physician's Office	Covered at 100%, less $10 co-pay	After deductible, Covered at 70%
Ambulance Services – Ground and Air (Medically Necessary Only)	After deductible, Covered at 100%	After deductible, Covered at 100%
Hospital Services		
Inpatient Hospital Services 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	After deductible, Covered at 100%	After deductible, Covered at 80%
Outpatient Hospital Services Outpatient Surgery, Outpatient CT scans, PET scans, MRI and Nuclear Medicine	After deductible, Covered at 100%	After deductible, Covered at 80%
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests	After deductible, 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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Special Surgical Procedures		
Bariatric Surgery, Reduction Mammoplasty, Blepharoplasty of Upper Eyelids, Panniculectomy, Surgical Treatment of Male Gynecomastia, Procedures to Correct Obstructive Sleep Apnea	After deductible, Covered at 50% (surgical fees)	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible, Covered at 100% up to 60 days per year	Not Covered
Home Health Care	After deductible, Covered at 100% Up to 60 days per episode per year	Not Covered
Hospice Care	After deductible, Covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
Inpatient 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%
Outpatient Mental Health	Covered at 100%, less $10 co-pay	After deductible, Covered at 70%
Outpatient Substance Abuse Services	Covered at 100%, less $10 co-pay	After deductible, Covered at 70%
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible, 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	After deductible Covered at 100%	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible Covered at 100%	Not Covered
Infertility Treatment and Counseling and Sterilization	After deductible Covered at 50%	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	Covered at 100%, less $10 co-pay	Not Covered
Oral Surgery	After deductible, Covered at 100%	*After deductible, Covered at 80%
Temporomandibular Joint Syndrome (TMJ) Treatment	After deductible Covered at 50% (Surgical Fees)	*After deductible, Covered at 80% (Surgical Fees)
Orthognathic Surgery	After deductible Covered at 50% (Surgical Fees)	*After deductible, Covered at 80% (Surgical Fees)
Antineoplastic Drugs	After deductible, Covered at 100%	*After deductible, Covered at 80%
Intractable Pain	Covered at 100%, less $10 co-pay	*After deductible, Covered at 80%

Option A requires pre-notification or pre-authorization for most services.
*** Option B requires pre-authorization for certain services. See asterisked items.**

Summary of Benefits

	Retail	Mail Order
Prescription Drugs		
Generic	Covered with $10 co-pay	Covered with $20 co-pay
Formulary	Brand: Covered with $30 co-pay	Brand: Covered with $60 co-pay
	Brand Generic Available: Covered with $30 co-pay co-pay plus difference in cost between Brand and Generic	Brand Generic Available: Covered with $60 co-pay co-pay plus difference in cost between Brand and Generic
Non-Formulary*	Covered with $60 co-pay	Covered with $120 co-pay

****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.

This proposal is contingent upon:

* MHP is the only carrier offered.
* Employer contribution of at least 50% of the single rate.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP's right to adjust the SIC assignments as well as the rates in this proposal.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* Changes in federal, state or other applicable legislation or regulation requiring changes to this quotation.
* Rates subject to DIFS approval.