

HEALTH PLAN

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	\$500/\$1000	\$2000/\$4000
Physician Office Co-payment	\$40	After deductible, Covered at 70%
Emergency Room Co-payment	\$150	\$150
Urgent Care Co-payment	\$50	\$50
Outpatient Mental Health Co-payment	\$40	After deductible, Covered at 70%
Special Surgical Procedures	After deductible 50%	Not Covered
Durable Medical Equipment	After deductible 80%	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 80%	Not Covered
Coinsurance	After deductible 80%	After deductible 60%
Coinsurance Out-of-Pocket Maximum	\$1500/\$3000	\$3000/\$6000
Total Out-of-Pocket Maximum	\$6350/\$12700	\$6350/\$12700

**Physician Office Visits**

Physician Office Visits	Covered at 100%, less \$40 co-pay	After deductible, Covered at 70%
Specialist Office Visit	Covered at 100%, less \$40 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 \$40 co-pay	Not Covered

**Emergency Care**

Hospital Emergency Room	Covered at 100%, less \$150 co-pay (Co-payment waived if admitted)	Covered at 100%, less \$150 co-pay (Co-payment waived if admitted)
Urgent Care Center	Covered at 100%, less \$50 co-pay	Covered at 100%, less \$50 co-pay
Physician's Office	Covered at 100%, less \$40 co-pay	After deductible, Covered at 70%
Ambulance Services – Ground and Air (Medically Necessary Only)	After deductible, Covered at 80%	After deductible, Covered at 80%

**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 Inclu	After deductible, Covered at 80%	After deductible, Covered at 60%
<i>Outpatient Hospital Services</i> Outpatient Surgery, Outpatient CT scans, PET scans, MRI and Nuclear Medicine	After deductible, Covered at 80%	After deductible, Covered at 60%

**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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<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 50% (surgical fees)	Not Covered
<b>Alternatives to Hospital Care</b>		
Skilled Nursing Care	After deductible, Covered at 80% up to 60 days per year	Not Covered
Home Health Care	After deductible, Covered at 80% Up to 60 days per episode per year	Not Covered
Hospice Care	After deductible, Covered at 100%	Not Covered
<b>Mental Health and Substance Abuse Services</b>		
Inpatient Mental Health	After deductible, Covered at 80%	*After deductible, Covered at 60%
Intermediate Substance Abuse Treatment	After deductible, Covered at 80%	*After deductible, Covered at 60%
Outpatient Mental Health	Covered at 100%, less \$40 co-pay	After deductible, Covered at 70%
Outpatient Substance Abuse Services	Covered at 100%, less \$40 co-pay	After deductible, Covered at 70%
<b>Other Services</b>		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible, Covered at 80% Up to 60 visits per condition per year	*After deductible, Covered at 60% Up to 60 visits per condition per year
Chiropractic Spinal Manipulation/Treatment	Not Covered	Not Covered
Durable Medical Equipment	After deductible Covered at 80%	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible Covered at 80%	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 \$40 co-pay	Not Covered
Oral Surgery	After deductible, Covered at 80%	*After deductible, Covered at 60%
Temporomandibular Joint Syndrome (TMJ) Treatment	After deductible Covered at 80% (Surgical Fees)	*After deductible, Covered at 60% (Surgical Fees)
Orthognathic Surgery	After deductible Covered at 80% (Surgical Fees)	*After deductible, Covered at 60% (Surgical Fees)
Antineoplastic Drugs	After deductible, Covered at 80%	*After deductible, Covered at 60%
Intractable Pain	Covered at 100%, less \$40 co-pay	*After deductible, Covered at 60%

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

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



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	<i>Retail</i>	<i>Mail Order</i>
<b>Prescription Drugs</b>		
<b>Generic</b>	Covered with \$10 co-pay	Covered with \$20 co-pay
<b>Formulary</b>	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
<b>Non-Formulary**</b>	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

**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.