

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	\$20	After Deductible, Covered at 70%
Emergency Room copayment	\$200	\$200
Urgent Care copayment	\$20	\$20
Outpatient Mental Health copayment	\$20	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 \$20 copay	After Deductible, Covered at 70%
Specialist Office Visit	Covered at 100%, less \$20 copay	After Deductible, Covered at 70%
Preventative and Physician Office Services		
Health Maintenance Exams	Covered at 100%, less \$20 copay	After Deductible, Covered at 70%
Routine gynecological exams and pap	Covered at 100%, less \$20 copay	After Deductible, Covered at 70%
Well-child care	Covered at 100%, less \$20 copay	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 \$200 copay (copayment waived if admitted)	Covered at 100%, less \$200 copay (copayment waived if admitted)
Urgent Care Center	Covered at 100%, less \$20 copay	Covered at 100%, less \$20 copay
Physician's Office	Covered at 100%, less \$20 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.

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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 70%
Intermediate Substance Abuse Treatment	Covered at 100%	After Deductible, Covered at 70%
Outpatient Mental Health	Covered at 100%, less \$20 copay	After Deductible, Covered at 70%
Outpatient Substance Abuse Services	Covered at 100%, less \$20 copay	After Deductible, Covered at 70%
Other Services		
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 \$20 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		
Generic	Retail	Mail Order
	Covered with \$10 copay	Covered with \$20 copay
Formulary	Brand: \$30 copay	Brand: \$60 copay
	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**	Covered with \$60 copay	Covered with \$120 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.