

State of Michigan Plan N072 – N073 Group Number 190053

PEALTH PLAN COMMUNITY SUMMARY OF BENEFITS In referrals required for In-Network Specially to referral required for In-Network Specially to referral required for In-Network Specially to sea early required to may MHP provider for the assertics listed below. The member can required by the PCP for these services into the In-Network special staffice. Part Part Deductible Copayments and Dellar Maximums Plan Yar Deductible Copayment \$200 Copay Copayment Wahed if Admitted) \$250.530.300 Playsican Office Copayment \$200 Copay (Copayment Wahed if Admitted) \$200 Copay (Copa	MICLOICII		·
SUMMARY OF BENEFITS No referrals required for in Network Specialty consultations* or for the care provided in the in Network Specialty consultations* or for the care provided in the in Network specialty consultations* or for the care provided in the in Network specialty of the Covered, there is no Option B benefit. Provider balance bill may apply. Deductibles, Copayments and Dollar Maximums Plan Year Deductible 13125,7550 \$250,7550 \$250,5550 Physician Office Copayment \$200 Copay Copay Copayment \$200 Copay \$200 Copay	LIEALTH DLAN COMMUNITY	Option A Benefit (In-Network)	
Deductibles, Copayments and Dollar Maximums Plan Year Deductible S129/S250 S250/S500 Physician Office Copayment S20 Copay S20 Copay S20 Copay After Deductible, Covered at 70% Secial Surgical Procedures Copayment S20 Copay S20	HEALTH PLAN COMMONITY	N. C. I. S. I.C. I. N. S. I.O. S. I.	
Deductibles, Copsyments and Dollar Maximums Plan Year Deductible Plan Year Deductible S250 Spay After Deductible S250 Spay After Deductible, Covered at 70% Not Covered After Deductible, Covered at 70% Not Covered After Deductible, Covered at 80% Total Out-of-Pocket Maximum S200 Spay Physician Office Visit Physician Office Visit After Deductible, Covered at 70% After Deductible, Covered at 80% A	STIMMADY OF BENEFITS		
Plan Year Deductible. Copayments and Dollar Maximums Plan Year Deductible S125/\$250 S250/\$500 Physician Office Copayment S20 Copay Copayment S20 Copay Urgent Care Copayment S20 Copay Urgent Care Copayment S20 Copay	SOMMANT OF BENEFITS		
Plan Year Deductible \$125/8250 \$250/8500 After Deductible, Covered at 70% Engregory Rom Copyment \$20 Copay (Copayment Waived if Admitted) \$200 Copay (Depayment Waived if Admitted) \$200 Copay \$20 Copay (Depayment Waived if Admitted) \$200 Copay \$20 Copay After Deductible, Covered at 70% Septial Surgical Procedures Copayment \$20 Copay After Deductible, Covered at 70% Not Covered Durable Medical Equipment After Deductible, Covered at 100% Not Covered Durable Medical Equipment Covered at 100% Not Covered C			
Physician Office Copayment \$20 Copay (Copayment Waived if Admitted) \$20 Copay \$20 Copay (Copayment Waived if Admitted)	Deductibles, Copayments and Dollar Maximums		
Emergency Room Copayment \$200 Copay (Copayment Waived if Admitted) \$200 Copay	Plan Year Deductible	\$125/\$250	\$250/\$500
Urgent Care Copayment S20 Copay S20 Copay After Deductible, Covered at 70% Special Surgical Procedures Opayment After Deductible, Covered at 100% Not Covered Durable Medical Equipment Covered at 100% Not Covered Prosthetics, Orthotics and Corrective Covered at 100% Not Covered Opayment S2,000/\$4,000 After Deductible, Covered at 80% After Deductible, Covered at 70% Specialist Office Visit S20 Copay After Deductible, Covered at 70% Specialist Office Visit S20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Specialist Office Visit S20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Specialist Office Visit S20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Specialist Office Visit S20 Copay After Deductible, Covered at 70% Well-Child Care Covered at 100% After Deductible, Covered at 70% Medical Vision Exams S20 Copay After Deductible, Covered at 70% After Deductible, Covered at 80% *After Deductibl	Physician Office Copayment	\$20 Copay	After Deductible, Covered at 70%
Outpatient Mental Health Copayment Special Surgical Procedures Copayment After Deductible, Covered at 100% Not Covered Durable Medical Equipment Covered at 100% Not Covered Coinsurance Covered at 100% Not Covered Coinsurance Covered at 100% After Deductible, Covered at 80% Total Out-of Pocket Maximum Specialist Office Visits Physician Office Visit Specialist Office Services Operated at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Medical Vision Exams Specialist Office Visit Specialist Office Visit Specialist Office Visit Specialist Office Visit Special Office Visit Special Office Office Visit Office Office Visit Office Visit Office Visit Office Office Visit Office Visit Office Vi	Emergency Room Copayment	\$200 Copay (Copayment Waived if Admitted)	\$200 Copay
Special Surgical Procedures Copayment Durable Medical Equipment Covered at 100% Not Covered Prosthetics, Orthotics and Corrective Coinsurance Covered at 100% After Deductible, Covered at 80% Not Covered Coinsurance Covered at 100% After Deductible, Covered at 80% Not Covered at 100% After Deductible, Covered at 80% Not Covered at 100% After Deductible, Covered at 80% Not Covered at 100% After Deductible, Covered at 80% Not Covered at 100% After Deductible, Covered at 70% Not Covered at 70% Not Covered at 70% Not Covered at 70% After Deductible, Covered at 70% Not Covered at 70% Not Covered at 70% Not Covered at 70% Not Covered at 70% After Deductible, Covered at 70% Not Covered at 70% After Deductible, Covered at 70% Not Cove	Urgent Care Copayment	\$20 Copay	\$20 Copay
Durable Medical Equipment Prosthetics, Orthotics and Corrective Covered at 100% Not Covered Consurance Covered at 100% After Deductible, Covered at 80% S2,000;84,000 S2,0	Outpatient Mental Health Copayment	\$20 Copay	After Deductible, Covered at 70%
Prosthetics, Orthotics and Corrective Coinsurance Covered at 100% After Deductible, Covered at 80% Total Out-of-Pocket Maximum Sz.000/\$4,000 Sz.000/\$4,000 Sz.000/\$4,000 Sz.000/\$4,000 Physician Office Visit Physician Office Visit Specialist Office Visit Specialist Office Visit Sz0 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Preventative and Physician Office Services Health Maintenance Exams Covered at 100% After Deductible, Covered at 70% Boutine GYN Exams Pap Smears Covered at 100% After Deductible, Covered at 70% Well-Child Care Covered at 100% After Deductible, Covered at 70% Minmunizations Covered at 100% After Deductible, Covered at 70% Immunizations Covered at 100% After Deductible, Covered at 70% Not Covered Pre Natal Care Covered at 100% After Deductible, Covered at 70% Ambulance Services After Deductible, Covered at 70% After Deductible, Covered at 80% *After Deductible, Covered at 80%	Special Surgical Procedures Copayment	After Deductible, Covered at 100%	Not Covered
Coinsurance Covered at 100% After Deductible, Covered at 80% Total Out-of-Pocket Maximum \$2,000/\$4,000 \$2,000/\$4,000 \$2,000/\$4,000 \$Physician Office Visits \$20 Copay After Deductible, Covered at 70% Specialist Office Visit \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Proventative and Physician Office Services Health Maintenance Exams Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Overed at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Overed at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Overed at 100% After Deductible, Covered at 70% Arter Deductible, Covered at 70% Overed at 70% Arter Deductible, Covered at 80% Overed at 80% Arter Deductible, Covered at 70% Arter Deductible, Covered at 80% Arter Deductible, Covered at 80% Arter Deduc	Durable Medical Equipment	Covered at 100%	Not Covered
Total Out-of-Pocket Maximum \$2,000/\$4,000 \$2,000/\$4,000 \$2,000/\$4,000 \$2,000/\$4,000 \$2,000/\$4,000 \$2,000/\$4,000 After Deductible, Covered at 70% Specialist Office Visit \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% Preventative and Physician Office Services Health Maintenance Exams Covered at 100% After Deductible, Covered at 70% Routine GYN Exams Pap Smears Covered at 100% After Deductible, Covered at 70% Mell-Child Care Covered at 100% After Deductible, Covered at 70% Not Covered Immunizations Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 70% After Deductible, Covered at 80% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 80% After Deductible, Covered at 70% Afte	Prosthetics, Orthotics and Corrective	Covered at 100%	Not Covered
Physician Office Visit Physician Office Visit Specialist Office Visit After Deductible, Covered at 70% Preventative and Physician Office Services Health Maintenance Exams Covered at 100% After Deductible, Covered at 70% Notine 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% After Deductible, Covered at 70% Not Covered Pre Natal Care Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Medical Vision Exams Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Medical Vision Exams Special Emergency Room Special Emergency Room After Deductible, Covered At 70% After Deductible, Covered At 80% Diagnostic and Therapeutic Services and Tosts Laboratory Tests After Deductible, Covered At 70% After Deductible, Covered At 70%	Coinsurance	Covered at 100%	After Deductible, Covered at 80%
Prysician Office Visit \$20 Copay After Deductible, Covered at 70% Specialist Office Visit \$20 Copay After Deductible, Covered at 70% Proventative and Physician Office Services Health Maintenance Exams Covered at 100% After Deductible, Covered at 70% Boutine 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% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Boutine Mammogram Covered at 100% After Deductible, Covered at 70% Injections Covered at 100% After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay After Deductible, Covered at 70% Ambulance Services – Ground Air (Medically Necessary Only) After Deductible, Covered at 100% After Deductible, Covered at 80% Out-Patient Hospital Services: Out-Patient Surger, Despital Services and Fests Laboratory Tests Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 70% After Deductible, Covered at 80% After Deductible, Covered at 70%	Total Out-of-Pocket Maximum	\$2,000/\$4,000	\$2,000/\$4,000
Specialist Office Visit Preventative and Physician Office Services 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% Well-Child Care Covered at 100% After Deductible, Covered at 70% Immunizations Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Redical Vision Exams Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Medical Vision Exams Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Emergency Care Hospital Emergency Room Sour Copay After Deductible, Covered at 70% After Deductible, Covered at 100% After Deductible, Covered at 100% Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services, Anshtesia, Laboratory Radiology, Chemotherapy, Inhalation Therapy, Hemodialysis, Physical Speech and Occupational Therapy, Hemodialysis, Physica	Physician Office Visits		
Preventative and Physician Office Services 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% Mot Covered Pre Natal Care Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Medical Vision Exams Covered at 100% After Deductible, Covered at 70% Medical Vision Exams Success Emergency Care Hospital Emergency Room Success Urgent Care Center Success Physician's Office Ambulance Services – Ground Air (Medically Necessary Only) After Deductible, Covered at 100% After Deductible, Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 100% *After Deductible, Covered at 80% Surgery Related Services: Semi-Private Room; Surgery Related Services: Semi-Private Room; Surgery Related Services: Semi-Private Room; Surgery Related Services: Nensthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hamodialysis, Physical, Speech and Coupational Therapy, Transplant Services After Deductible, Covered at 100% *After Deductible, Covered at 80% President Office After Deductible, Covered at 100% After Deductible, Covered at 80% *After Deductible, Covered at 80% *After Deductible, Covered at 80% *After Deductible, Covered at 100% After Deductible, Covered at 100% After Deductible, Covered at 100% *After Deductible, Covered at 100%	Physician Office Visit	\$20 Copay	After Deductible, Covered at 70%
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% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Injections Covered at 100% After Deductible, Covered at 70% Medical Vision Exams Covered at 100% After Deductible, Covered at 70% Medical Vision Exams Success Emergency Care Hospital Emergency Room Urgent Care Center Success Physician's Office Ambulance Services – Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology, Chemotherapy, Inhalation Therapy, Hemodialysis; Physical, Speech and Coupaptional Therapy, Transplant Services Naternity Care (hospital only); Physician Services Including Consultation Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient Surgery	Specialist Office Visit	\$20 Copay	After Deductible, Covered at 70%
Routine GYN Exams Pap Smears Covered at 100% Well-Child Care Covered at 100% After Deductible, Covered at 70% Immunizations Covered at 100% Not Covered After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Routine Mammogram Covered at 100% After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 100% *After Deductible, Covered at 80% *After Deductible, Covered at 70% After Deductible, Covered at 70%	Preventative and Physician Office Services		
Well-Child Care Immunizations Covered at 100% Covered at 100% Not Covered Pre Natal Care Covered at 100% Covered at 100% Routine Mammogram 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% After Deductible, Covered at 70% Medical Vision Exams Emergency Care Hospital Emergency Room Virgent Care Center Physician's Office Ambulance Services – Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Emodialysis; Physical, Speech and Occupational Therapy, Emodialysis; Physical, Speech and Occupational Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Hemodialon, Consultation Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Health Maintenance Exams	Covered at 100%	After Deductible, Covered at 70%
Immunizations Covered at 100% Pre Natal Care Covered at 100% 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% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay After Deductible, Covered at 70% Ambulance Services — Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hamodiany Inserty, Indeation Therapy, Hamodiany Inserty, Insertion Therapy, Hamodiany Services; Maternity Care (hospital only); Physician Services Including Consultation Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient To Spans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 80% After Deductible, Covered at 80%	Routine GYN Exams Pap Smears	Covered at 100%	After Deductible, Covered at 70%
Pre Natal Care Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70% Injections Covered at 100% After Deductible, Covered at 70% Injections Covered at 100% After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Medical Vision Exams \$20 Copay (Copayment Waived if Admitted) \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 70% After Deductible, Covered at 80% After Deductible, Covered at 70% After Deductible, Covered at 70	Well-Child Care	Covered at 100%	After Deductible, Covered at 70%
Routine Mammogram Covered at 100% Injections Covered at 100% After Deductible, Covered at 70% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay Physician's Office \$20 Copay After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 70% After Deductible, Covered at 100% Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Transplant Services (Naternity Care (hospital only); Physician Services Including Consultation Out-Patient Hospital Services Including Consultation Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70% After Deductible, Covered at 70%	Immunizations	Covered at 100%	Not Covered
Injections Covered at 100% Medical Vision Exams \$20 Copay After Deductible, Covered at 70% Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay \$20 Copay \$20 Copay Physician's Office Anbulance Services — Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Hemodialysis; Physical Services: Maternity Care (hospital only); Physician Services Including Consultation Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Pre Natal Care	Covered at 100%	After Deductible, Covered at 70%
Medical Vision Exams Emergency Care Hospital Emergency Room Urgent Care Center Physician's Office Ambulance Services – Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services; Anesthesia, Laboratory Radiology, Chemotherapy, Inhalation Therapy, Transplant Services, Maternity Care (hospital only); Physician Services Induding Consultation Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests After Deductible, Covered at 100% After Deductible, Covered at 100% After Deductible, Covered at 80% *After Deductible, Covered at 70%	Routine Mammogram	Covered at 100%	After Deductible, Covered at 70%
Emergency Care Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) \$200 Copay (Copayment Waived if Admitted) Urgent Care Center \$20 Copay \$20 Copay \$20 Copay \$20 Copay After Deductible, Covered at 70% Ambulance Services – Ground Air (Medically Necessary Only) After Deductible, Covered at 100% Hospital Services In-Patient Hospital Services: 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 Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Injections	Covered at 100%	After Deductible, Covered at 70%
Hospital Emergency Room \$200 Copay (Copayment Waived if Admitted) \$20 Copay \$20 Copay \$20 Copay \$20 Copay \$20 Copay After Deductible, Covered at 70% Ambulance Services – Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy, Inhalation Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Hemodialysis; Physical, Speech and Occupational Therapy, Hemodialysis (Care (hospital Services) unt-Patient Burgery, Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% \$20 Copay After Deductible, Covered at 100% After Deductible, Covered at 100% *After Deductible, Covered at 80% *After Deductible, Covered at 80% *After Deductible, Covered at 80% After Deductible, Covered at 80% *After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 70%	Medical Vision Exams	\$20 Copay	After Deductible, Covered at 70%
Urgent Care Center \$20 Copay \$20 Copay After Deductible, Covered at 70% Ambulance Services – Ground Air (Medically Necessary Only) After Deductible, Covered at 100% Hospital Services In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy; Ihnalation Therapy; Hemodialysis; Physical, Speech and Occupational Therapy; Transplant Services; Maternity Care (hospital only); Physician Services: Out-Patient Surgery, Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Emergency Care		
Physician's Office \$20 Copay After Deductible, Covered at 70% Ambulance Services – Ground Air (Medically Necessary Only) After Deductible, Covered at 100% Hospital Services In-Patient Hospital Services: 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 Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Hospital Emergency Room		\$200 Copay (Copayment Waived if Admitted)
Ambulance Services — Ground Air (Medically Necessary Only) Hospital Services In-Patient Hospital Services: 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 Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests After Deductible, Covered at 100% After Deductible, Covered at 100% *After Deductible, Covered at 80% *After Deductible, Covered at 80% After Deductible, Covered at 70%	Urgent Care Center	\$20 Copay	\$20 Copay
In-Patient Hospital Services: Semi-Private Room; Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy; Inhalation Therapy; Hemodialysis; Physical, Speech and Occupational Therapy; Transplant Services; Maternity Care (hospital Services Including Consultation) Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests After Deductible, Covered at 100% *After Deductible, Covered at 80% After Deductible, Covered at 70%	,	\$20 Copay	After Deductible, Covered at 70%
In-Patient Hospital Services: 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 Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests After Deductible, Covered at 100% *After Deductible, Covered at 80% *After Deductible, Covered at 70%		After Deductible, Covered at 100%	After Deductible, Covered at 100%
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 Out-Patient Hospital Services: Out-Patient Surgery, Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests After Deductible, Covered at 100% *After Deductible, Covered at 80%	•		
Out-Patient Hospital Services: Out-Patient Surgery, After Deductible, Covered at 100% *After Deductible, Covered at 80% Diagnostic and Therapeutic Services and Tests Covered at 100% After Deductible, Covered at 70%	Surgery Related Services; Anesthesia, Laboratory Radiology; Chemotherapy: Inhalation Therapy: Hemodialysis: Physical	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine Diagnostic and Therapeutic Services and Tests Laboratory Tests Covered at 100% After Deductible, Covered at 80% After Deductible, Covered at 80% After Deductible, Covered at 70%			
Laboratory Tests Covered at 100% After Deductible, Covered at 70%	Out-Patient CT Scans, PET Scans, MRI Nuclear Medicine	After Deductible, Covered at 100%	*After Deductible, Covered at 80%
·			
Diagnostic X-ray, Including Mammography 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%

^{*}Requires pre-notification or pre-authorization for certain services.



State of Michigan Plan N072 – N073 Group Number 190053

	Option A Benefit (In-Network)	Option B Benefit (Out-of-Network)
SUMMARY OF BENEFITS	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.
Special Surgical Procedures		
Bariatric Surgery, Reduction Mammoplasty, Blepharophasty of Upper Eyelids, Panniculectomy, Surgical Treatment of Male Gynecomastia, Procedures to Correct Obstructive Sleep Apnea	After Deductible, Covered at 100% (surgical fees)	Not Covered
Alternatives to Hospital Care		
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
Mental Health and Substance Abuse Services		
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%
Other Services		
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 Up to 24 Visits Per Person, Per Plan Year	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%
PRESCRIPTION DRUG COVERAGE	RETAIL	MAIL ORDER
Generic	\$10 Copay	\$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**	\$60 Copay	\$120 Copay

^{*}Requires pre-notification or pre-authorization for certain services. ** 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.