

MCLAREN HEALTH PLAN

Summary of Benefits

DELTA STAFFING CUSTOM 2 QUOTE

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	\$2500/\$5000	\$3000/\$6000
Physician Office Co-Payment	\$25	After Deductible, Covered at 70%
Emergency Room Co-Payment	\$100	\$100
Urgent Care Co-Payment	\$50	\$50
Outpatient Mental Health Co-Payment	\$25	After Deductible, Covered at 70%
Special Surgical Procedures Co-Payment	50%	Not Covered
Durable Medical Equipment	80%	Not Covered
Prosthetics, Orthotics and Corrective	80%	Not Covered
Coinsurance	80%	60%
Out-of-Pocket Maximum	\$2500/\$5000	\$3000/\$6000
Physician Office Visits		
Physician Office Visits	Covered at 100% less \$25 Copay	After Deductible, Covered at 70%
Specialist Office Visit	Covered at 100% less \$25 Copay	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%
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	After Deductible, Covered at 80%	Not Covered
Emergency Care		
Hospital Emergency Room	Covered at 100%, less \$100 Copay (Co-Payment waived if admitted)	Covered at 100%, less \$100 Copay (Co-Payment waived if admitted)
Urgent Care Center	Covered at 100%, less \$50 Copay	Covered at 100%, less \$50 Copay
Physician's Office	Covered at 100% less \$25 Copay	After Deductible, Covered at 70%
Ambulance Services - Ground Air (Medically Necessary Only)	After Deductible, Covered at 80%	After Deductible, Covered at 60%
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	After Deductible, Covered at 80%	*After Deductible, Covered at 60%
Out-Patient Hospital Services:		
Out-Patient Surgery, Outpatient CT Scans, PET Scans, MRI 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%

MCLAREN HEALTH PLAN

Summary of Benefits

DELTA STAFFING CUSTOM 2 QUOTE

	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.
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 80% up to 60 days per person per year	Not Covered
Home Health Care	After Deductible, Covered at 80% up to 60 days per episode	Not Covered
Hospice Care	After Deductible, Covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
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 \$25 Copay	After Deductible, Covered at 70%
Outpatient Substance Abuse Services	Covered at 100% less \$25 Copay	After Deductible, Covered at 70%
Other Services		
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	Covered at 100% Up to \$500 per person per year	Covered at 100% Up to \$500 per person per year
Durable Medical Equipment	After Deductible, Covered at 80%	Not Covered
Prosthetics, Orthotics, Corrective Appliances	After Deductible, Covered at 80%	Not Covered
Infertility Treatment, Counseling, Sterilization, and Termination.	After Deductible, Covered at 50%	Not Covered
Reproductive Care, Family Planning Services	Covered at 100% less \$25 Copay	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 \$25 Copay	*After Deductible, Covered at 60%
Prescription Drug Coverage		
	Retail	Mail Order
Deductible	NA	NA
Generic	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 \$50 Copay	Covered with \$100 Copay
Contraceptives	Covered	Covered

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

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

** Prior Authorization or Step Therapy Required