McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058 (XS16-XF16)
HDHP 2000 - 100 - A With NQ3
2019 HDHP Summary of Benefits

Deductibles, Co-payments and Dollar Maximums	
Annual Deductible	Self Only: $2,000 Family: $4,000
Coinsurance	After deductible 0% coinsurance
Total Annual Out-of-Pocket Maximum	Self Only: $4,000 Family: $8,000
Physician Office Visits	
Physician Office Visits	After deductible 0% coinsurance
Specialist Office Visit	After deductible 0% coinsurance
Preventive Services	
Preventive Services as defined by the US Preventive Services Task Force. Examples of Preventive Services: • Well child visits • Certain Immunizations • Certain assessments and screenings for children and for adults • Breast cancer screening	No member cost sharing
Emergency Care	
Hospital Emergency Room	After deductible 0% coinsurance
Urgent Care Center	After deductible 0% coinsurance
Physician's Office	After deductible 0% coinsurance
Medically Necessary Ambulance Services - Ground and Air	After deductible 0% coinsurance
Hospital Services	
Inpatient Hospital Services	After deductible 0% coinsurance
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	
Outpatient Hospital Services	After deductible 0% coinsurance
Outpatient surgery and nuclear medicine	
Outpatient MRI, MRA, CAT, and PET scans	After deductible 0% coinsurance
Diagnostic and Therapeutic Services and Tests	
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 0% coinsurance
Diagnostic X-ray	After deductible 0% coinsurance
Special Surgical Procedures	
Surgical fees for: Bariatric surgery, reduction mammoplasty, blepharoplasty of upper eyelids, panniculectomy, surgical treatment of male gynecomastia, procedures to correct obstructive sleep apnea	After deductible 0% coinsurance
Alternatives to Hospital Care	
Skilled Nursing Care	After deductible 0% coinsurance Benefit maximum: up to 60 days per year
Home Health Care	After deductible 0% coinsurance Benefit maximum: up to 60 days per episode per year
Hospice Care	After deductible 0% coinsurance

Mental Health and Substance Abuse Services	
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 0% coinsurance
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 0% coinsurance
Outpatient Mental Health	After deductible 0% coinsurance
Outpatient Substance Abuse Services	After deductible 0% coinsurance
Other Services	
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 0% coinsurance Benefit maximum: up to 60 visits per condition per year
Outpatient Habilitative Services - Physical and Occupational Therapy, Applied Behavioral Analysis (ABA) for treatment of Autism Spectrum Disorder and Speech Therapies	After deductible 0% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	After deductible 0% coinsurance Benefit maximum: up to $1500 per person per year
Durable Medical Equipment	After deductible 0% coinsurance
Prosthetics, Orthotics and Corrective Appliances	After deductible 0% coinsurance
Infertility Treatment and Counseling	After deductible 0% coinsurance
Reproductive Care and Family Planning Services and Genetic Testing	After deductible 0% coinsurance
Oral Surgery	After deductible 0% coinsurance
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 0% coinsurance
Orthognathic Surgery (surgical fees)	After deductible 0% coinsurance
Antineoplastic Drugs	After deductible 0% coinsurance
Pain Management	After deductible 0% coinsurance

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	Retail	***Mail Order***
Prescription Drugs		
Generic	After deductible $10 co-pay	After deductible $20 co-pay
Formulary	Brand: After deductible $25 co-pay	Brand: After deductible $50 co-pay
	Brand with generic available: After deductible $25 co-pay plus the difference in cost between brand and generic.	Brand with generic available: After deductible $50 co-pay plus the difference in cost between brand and generic.
Non-Formulary*	After deductible $40 co-pay	After deductible $80 co-pay

****Prior Authorization or Step Therapy required.**

This Summary of Benefits is intended only to highlight the benefits provided by McLaren Health Plan Community and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the McLaren Health Plan Community 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 Certificate issued to the enrolling group, the Certificate will prevail. For answers to questions about information that appears in the summary, call Customer Service at (888) 327-0671.

MHP Community complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MHP Community does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHP Community:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact MHP Community's Compliance Officer.

If you believe that MHP Community has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with MHP Community's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48532, call: 866-866-2135, TTY 711, Fax: 877-733-5788, or Email mhpcompliance@mclaren.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MHP Community's Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܐ ܕܠܗܘܢ ܕܚܠܡܬܝܗܘܢ ܝܠܦܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).