DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Lansing School District
McLaren POS Traditional $500-0%; $10/$25/$40 Rx
Assumed Effective Date: 7/1/2019

	CURRENT PLAN McLaren POS Traditional $500-0%; $10/$25/$40 Rx		RENEWAL PLAN McLaren POS Traditional $500-0%; $10/$25/$40 Rx (Renewal)		OPTION 1 CoreSource SF POS Traditional $500-0%; $10/$25/$40 Rx	
Rate Period	7/1/18 - 6/30/19		7/1/19 - 6/30/20		7/1/19 - 6/30/20	
Purchased Plan Features	**In Network**		**In Network**		**In Network**	
Deductible						
Annual Deductible - 1P	$500		$500		$500	
Annual Deductible - 2P/FF	$1,000		$1,000		$1,000	
Additional Cost After Deductible						
Employee Coinsurance after Deductible	0%		0%		0%	
Coinsurance Max - 1P	N/A		N/A		N/A	
Coinsurance Max - 2P/FF	N/A		N/A		N/A	
Out of Pocket Maximum						
Max ded, coinsurance, copays - 1P	$7,350		$7,350		$7,350	
Max ded, coinsurance, copays - 2P/FF	$14,700		$14,700		$14,700	
Copayments						
Office Visit/Specialist	$25		$25		$25	
Urgent Care/ER	$35/$100		$35/$100		$35/$100	
Chiropractic Limit/Copay	$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.	
Rx Copay	$10/$25/$40		$10/$25/$40		$10/$25/$40	
Total Monthly Costs	Census	Rates	Census	Rates	Census	Rates
One Person (1P)	172	$613.80	172	$725.96	172	$613.80
Two Person (2P)	119	$1,462.31	119	$1,729.52	119	$1,462.31
Family (FF)	203	$1,636.29	203	$1,935.29	203	$1,636.29
Total Costs			**PEPM**	**Annual**	**PEPM**	**Annual**
Estimated Annual Cost	**$7,341,064**			**$8,682,502**		**$7,341,064**
Estimated Savings/(Increase) $				**($1,341,438.12)**		**$0.00**
Estimated Difference %				**-18.3%**		**0.0%**

SET SEG:

*Rates do not include $8.30 enrollment and billing service fee.

*Proposed rates are based on census provided by the district. Rates may change based on actual group enrollment and participation.

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Lansing School District
McLaren POS Traditional $1,000-0%; $10/$30/$60 Rx
Assumed Effective Date: 7/1/2019

	CURRENT PLAN		RENEWAL PLAN		OPTION 1	
	McLaren POS Traditional $1,000-0%; $10/$30/$60 Rx		**McLaren POS Traditional $1,000-0%; $10/$30/$60 Rx (Renewal)**		**CoreSource SF POS Traditional $1,000-0%; $10/$30/$60 Rx**	
Rate Period	7/1/18 - 6/30/19		7/1/19 - 6/30/20		7/1/19 - 6/30/20	
Purchased Plan Features	**In Network**		**In Network**		**In Network**	
Deductible						
Annual Deductible - 1P	$1,000		$1,000		$1,000	
Annual Deductible - 2P/FF	$2,000		$2,000		$2,000	
Additional Cost After Deductible						
Employee Coinsurance after Deductible	0%		0%		0%	
Coinsurance Max - 1P	N/A		N/A		N/A	
Coinsurance Max - 2P/FF	N/A		N/A		N/A	
Out of Pocket Maximum						
Max ded, coinsurance, copays - 1P	$7,350		$7,350		$7,350	
Max ded, coinsurance, copays - 2P/FF	$14,700		$14,700		$14,700	
Copayments						
Office Visit/Specialist	$25		$25		$25	
Urgent Care/ER	$50/$150		$50/$150		$50/$150	
Chiropractic Limit/Copay	$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.	
Rx Copay	$10/$30/$60 Rx		$10/$30/$60 Rx		$10/$30/$60 Rx	
Total Monthly Costs	Census	Rates	Census	Rates	Census	Rates
One Person (1P)	64	$578.49	64	$684.55	64	$578.49
Two Person (2P)	30	$1,378.20	30	$1,630.88	30	$1,378.20
Family (FF)	64	$1,542.17	64	$1,824.91	64	$1,542.17
Total Costs			**PEPM**	**Annual**	**PEPM**	**Annual**
Estimated Annual Cost	**$2,124,819**			**$2,514,382**		**$2,124,819**
Estimated Savings/(Increase) $				**($389,563.20)**		**$0.00**
Estimated Difference %				**-18.3%**		**0.0%**

SET SEG:

*Rates do not include $8.30 enrollment and billing service fee.

*Proposed rates are based on census provided by the district. Rates may change based on actual group enrollment and participation.

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Lansing School District
McLaren HMO HSA $2,000-0%; $10/$25/$40 Rx
Assumed Effective Date: 7/1/2019

	CURRENT PLAN		RENEWAL PLAN		OPTION 1	
	McLaren HMO HSA $2,000-0%; $10/$25/$40 Rx		**McLaren HMO HSA $2,000-0%; $10/$25/$40 Rx (Renewal)**		**CoreSource SF HMO HSA $2,000-0%; $10/$25/$40 Rx**	
Rate Period	7/1/18 - 6/30/19		7/1/19 - 6/30/20		7/1/19 - 6/30/20	
Purchased Plan Features	**In Network**		**In Network**		**In Network**	
Deductible						
Annual Deductible - 1P	$2,000		$2,000		$2,000	
Annual Deductible - 2P/FF	$4,000		$4,000		$4,000	
Additional Cost After Deductible						
Employee Coinsurance after Deductible	0%		0%		0%	
Coinsurance Max - 1P	N/A		N/A		N/A	
Coinsurance Max - 2P/FF	N/A		N/A		N/A	
Out of Pocket Maximum						
Max ded, coinsurance, copays - 1P	$4,000		$4,000		$4,000	
Max ded, coinsurance, copays - 2P/FF	$8,000		$8,000		$8,000	
Copayments						
Office Visit/Specialist	0% after ded.		0% after ded.		0% after ded.	
Urgent Care/ER	0% after ded.		0% after ded.		0% after ded.	
Chiropractic Limit/Copay	$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.		$1,500 per person per year max; 0% coins.	
Rx Copay	$10/$25/$40 Rx after ded.		$10/$25/$40 Rx after ded.		$10/$25/$40 Rx after ded.	
Total Monthly Costs	Census	Rates	Census	Rates	Census	Rates
One Person (1P)	25	$497.17	25	$534.13	25	$497.17
Two Person (2P)	11	$1,184.45	11	$1,272.51	11	$1,184.45
Family (FF)	29	$1,325.37	29	$1,423.91	29	$1,325.37
Total Costs			**PEPM**	**Annual**	**PEPM**	**Annual**
Estimated Annual Cost	**$766,727**			**$823,731**		**$766,727**
Estimated Savings/(Increase) $				**($57,003.84)**		**$0.00**
Estimated Difference %				**-7.4%**		**0.0%**

SET SEG:

*Rates do not include $8.30 enrollment and billing service fee.

*Proposed rates are based on census provided by the district. Rates may change based on actual group enrollment and participation.

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N295-Renewal
2019 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. 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	$1000/$2000
Coinsurance	After deductible 0% coinsurance	After deductible 20% coinsurance
Coinsurance Annual Out-of-Pocket Maximum	None	$2500/$5000
Total Annual Out-of-Pocket Maximum	$7350/$14700	Unlimited
Physician Office Visits		
Physician Office Visits	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
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	After deductible 30% coinsurance Provider balance bill may apply
Emergency Care		
Hospital Emergency Room	$100 co-pay - no deductible (Copayment waived if admitted)	$100 co-pay - no deductible Provider balance bill may apply (Copayment waived if admitted)
Urgent Care Center	$35 co-pay - no deductible	$35 co-pay - no deductible Provider balance bill may apply
Physician's Office	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Medically Necessary Ambulance Services - Ground and Air	After deductible 0% coinsurance	After deductible 0% coinsurance Provider balance bill may apply
Hospital Services		
Inpatient Hospital Services 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	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient Hospital Services Outpatient surgery and nuclear medicine	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient MRI, MRA, CAT, and PET scans	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic X-ray	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N295-Renewal
2019 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
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 50% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 0% coinsurance Benefit maximum: 60 days per year	Not Covered
Home Health Care	After deductible 0% coinsurance Benefit maximum: 60 visits per episode per year	Not Covered
Hospice Care	After deductible covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient Mental Health	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 0% coinsurance Benefit maximum: 60 visits per condition per year	After deductible 20% coinsurance Provider balance bill may apply Benefit maximum: 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	After deductible 20% coinsurance Provider balance bill may apply Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	0% coinsurance - no deductible Benefit maximum: $1500 per person per year	0% coinsurance - no deductible Provider balance bill may apply Benefit maximum: $1500 per person per year
Durable Medical Equipment	After deductible 0% coinsurance	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 0% coinsurance	Not Covered
Infertility Treatment and Counseling	After deductible 50% coinsurance	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	$25 co-pay - no deductible	Not Covered
Oral Surgery	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Pain Management	$25 co-pay - no deductible	After deductible 20% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N295-Renewal
2019 POS Summary of Benefits

	Retail	*Mail Order*
Prescription Drugs		
Generic	$10 co-pay	$20 co-pay
Formulary	Brand: $25 co-pay	Brand: $50 co-pay
	Brand - Generic Available: $25 co-pay plus difference in cost between Brand and Generic	Brand - Generic Available: $50 co-pay plus difference in cost between Brand and Generic
Non-Formulary*	$40 co-pay	$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، ܟܐ ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܦܘܬܐ 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).

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N296-Renewal
2019 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
Deductibles, Co-payments and Dollar Maximums		
Annual Deductible	$1000/$2000	$2000/$4000
Coinsurance	After deductible 0% coinsurance	After deductible 20% coinsurance
Coinsurance Annual Out-of-Pocket Maximum	None	$2500/$5000
Total Annual Out-of-Pocket Maximum	$7350/$14700	Unlimited
Physician Office Visits		
Physician Office Visits	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
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	After deductible 30% coinsurance Provider balance bill may apply
Emergency Care		
Hospital Emergency Room	$150 co-pay - no deductible (Copayment waived if admitted)	$150 co-pay - no deductible Provider balance bill may apply (Copayment waived if admitted)
Urgent Care Center	$50 co-pay - no deductible	$50 co-pay - no deductible Provider balance bill may apply
Physician's Office	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Medically Necessary Ambulance Services - Ground and Air	After deductible 0% coinsurance	After deductible 0% coinsurance Provider balance bill may apply
Hospital Services		
Inpatient Hospital Services 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	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient Hospital Services Outpatient surgery and nuclear medicine	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient MRI, MRA, CAT, and PET scans	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic X-ray	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N296-Renewal
2019 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
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 50% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 0% coinsurance Benefit maximum: 60 days per year	Not Covered
Home Health Care	After deductible 0% coinsurance Benefit maximum: 60 visits per episode per year	Not Covered
Hospice Care	After deductible covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Outpatient Mental Health	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	$25 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 0% coinsurance Benefit maximum: 60 visits per condition per year	After deductible 20% coinsurance Provider balance bill may apply Benefit maximum: 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	After deductible 20% coinsurance Provider balance bill may apply Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	0% coinsurance - no deductible Benefit maximum: $1500 per person per year	0% coinsurance - no deductible Provider balance bill may apply Benefit maximum: $1500 per person per year
Durable Medical Equipment	After deductible 0% coinsurance	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 0% coinsurance	Not Covered
Infertility Treatment and Counseling	After deductible 50% coinsurance	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	$25 co-pay - no deductible	Not Covered
Oral Surgery	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 0% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Pain Management	$25 co-pay - no deductible	After deductible 20% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

LANSING SCHOOL DISTRICT-190058
N296-Renewal
2019 POS Summary of Benefits

	Retail	*Mail Order*
Prescription Drugs		
Generic	$10 co-pay	$20 co-pay
Formulary	Brand: $30 co-pay	Brand: $60 co-pay
	Brand - Generic Available: $30 co-pay plus difference in cost between Brand and Generic	Brand - Generic Available: $60 co-pay plus difference in cost between Brand and Generic
Non-Formulary*	$60 co-pay	$120 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 ܡܫܬܥܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܝܚܘܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. 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).

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

McLaren HEALTH PLAN COMMUNITY

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

	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 ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝ ܒܠܘܟܘܢ ܕܡܣܬܢܕܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. 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).

Family Healthcare Center

Dr. Breanna O'Keefe, D.O.

What is the SET SEG Family Healthcare Center?

The SET SEG Family Healthcare Center is a one-stop-shop for all of your primary care needs. Whether you need medication to help you through a pesky cold or an x-ray to determine if that fall caused a break or a bad sprain, Dr. O'Keefe and the Family Healthcare Center are able to help.

- Primary & urgent care
- Same-day and next-day availability
- 30+ minute appointments
- Pharmacy on-site
- X-ray
- Stress & depression
- Weight management
- Back & neck pain
- Sprains & strains

How much does it cost?

The cost of your visit depends on two things:

1. The reason for your visit
2. Whether you are on a traditional health plan or an HSA health plan

If you are on a traditional health plan, all visits to the Healthcare Center are $0. If you are on an HSA health plan, preventive visits (e.g., annual physical, cholesterol screening) are $0, and all acute care visits (e.g., cold and flu) are $40.

Hours & Location

7402 Westshire Dr., Lansing, MI 48917

Monday:	7:00 am - 3:00 pm
Tuesday:	11:00 am - 5:00 pm
Wednesday:	1:00 pm - 7:00 pm
Thursday:	11:00 am - 5:00 pm
Friday:	7:00 am - 3:00 pm

> "Dr. O'Keefe did more for me in 40 minutes than my previous doctor was able to do for me in seven years."
>
> - Charlotte Public Schools Employee

setseg.org/healthcarecenter | 517-482-2420

SET SEG Family Healthcare Center
Operated by CareATC