McLaren HEALTH PLAN COMMUNITY

Almont Community Schools
Option 5 HDHP 1400 - 80 - Plan B, HQ3
2023 HDHP Summary of Benefits

Please note: BIB summary is illustrative
Finalized 2023 BIB summary will be provided once available.

Deductibles, Co-payments and Dollar Maximums	
Annual Deductible	Self Only: $1,400 Family: $2,800
Coinsurance	After deductible 20% coinsurance
Total Annual Out-of-Pocket Maximum	Self Only: $2,800 Family: $5,600
Physician Office Visits	
Physician Office Visits	After deductible 20% coinsurance
Specialist Office Visit	After deductible 20% 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 20% coinsurance
Urgent Care Center	After deductible 20% coinsurance
Physician's Office	After deductible 20% coinsurance
Medically Necessary Ambulance Services - Ground and Air	After deductible 20% coinsurance
Hospital Services	
Inpatient Hospital Services	After deductible 20% 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 20% coinsurance
Outpatient surgery and nuclear medicine	
Outpatient MRI, MRA, CAT, and PET scans	After deductible 20% coinsurance
Diagnostic and Therapeutic Services and Tests	
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 20% coinsurance
Diagnostic X-ray	After deductible 20% 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 20% coinsurance
Alternatives to Hospital Care	
Skilled Nursing Care	After deductible 20% coinsurance Benefit maximum: up to 60 days per year
Home Health Care	After deductible 20% coinsurance Benefit maximum: up to 60 days per episode per year
Hospice Care	After deductible 20% coinsurance

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Mental Health and Substance Abuse Services	
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 20% coinsurance
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 20% coinsurance
Outpatient Mental Health	After deductible 20% coinsurance
Outpatient Substance Abuse Services	After deductible 20% coinsurance
Other Services	
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 20% 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 20% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	After deductible 20% coinsurance Benefit maximum: up to $1500 per person per year
Durable Medical Equipment	After deductible 20% coinsurance
Prosthetics, Orthotics and Corrective Appliances	After deductible 20% coinsurance
Infertility Treatment and Counseling	After deductible 20% coinsurance
Voluntary Termination of Pregnancy	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	After deductible 20% coinsurance
Oral Surgery	After deductible 20% coinsurance
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 20% coinsurance
Orthognathic Surgery (surgical fees)	After deductible 20% coinsurance
Antineoplastic Drugs	After deductible 20% coinsurance
Pain Management	After deductible 20% coinsurance

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	Retail	*Mail Order*
Prescription Drugs		
Generic	After deductible $15 co-pay	After deductible $30 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 $50 co-pay	After deductible $100 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.

Effective Date:	01/01/23

Contract Type:	**Rates:**
Single	$364.07
Double	$873.79
Family	$1,092.23

This proposal is contingent upon:

* Employer contribution of at least 50% of the single rate.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* No changes in federal, state or other applicable legislation or regulation requiring changes to this proposal.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP Community's right to adjust the SIC assignments as well as the rates in this proposal.
* State regulatory approval of rates.
* **PENDING DIFS APPROVAL**

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.

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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: ATENCION: 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 ܐܢܬ ܟܐ ܗܡܙܡܝܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܦܠܚܬ ܚܠܡܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ 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: CHU Y: Nêu bạn nói Tiêng Việt, có các dịch vụ hô trợ ngôn ngữ miên phí dành cho bạn. Gọi sô 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

Almont Community Schools
Option 20 HDHP POS 1400 - 100 - Plan B, HQ3, HT6
2023 HDHP Summary of Benefits

Please note: BIB summary is illustrative
Finalized 2023 BIB summary will be provided once available.

	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	Self Only: $1,400 Family: $2,800	Self Only: $2,800 Family: $5,600
Coinsurance	After deductible 0% coinsurance	After deductible 30% coinsurance
Total Annual Out-of-Pocket Maximum	Self Only: $2,800 Family: $5,600	Self Only: $5,600 Family: $11,200
Physician Office Visits		
Physician Office Visits	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	After deductible 0% coinsurance	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	Not Covered
Emergency Care		
Hospital Emergency Room	After deductible 0% coinsurance	After deductible 0% coinsurance Provider balance bill may apply
Urgent Care Center	After deductible 0% coinsurance	After deductible 0% coinsurance Provider balance bill may apply
Physician's Office	After deductible 0% coinsurance	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	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
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	After deductible 30% coinsurance Provider balance bill may apply
Outpatient surgery and nuclear medicine		
Outpatient MRI, MRA, CAT, and PET scans	After deductible 0% coinsurance	After deductible 30% 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

Almont Community Schools
Option 20 HDHP POS 1400 - 100 - Plan B, HQ3, HT6
2023 HDHP Summary of Benefits

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Finalized 2023 BIB summary will be provided once available.

	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 0% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 0% coinsurance Benefit maximum: up to 60 days per year	Not Covered
Home Health Care	After deductible 0% coinsurance Benefit maximum: up to 60 days per episode per year	Not Covered
Hospice Care	After deductible 0% coinsurance	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 30% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Mental Health	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	After deductible 0% coinsurance	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: up to 60 visits per condition per year	After deductible 30% coinsurance Benefit maximum: up to 60 visits per condition per year Provider balance bill may apply
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 30% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism Provider balance bill may apply
Chiropractic Spinal Manipulation/Treatment	After deductible 0% coinsurance Benefit maximum: up to $1500 per person per year	After deductible 0% coinsurance Benefit maximum: up to $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 0% coinsurance	Not Covered
Voluntary Termination of Pregnancy	After deductible 20% coinsurance	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	After deductible 0% coinsurance	Not Covered
Oral Surgery	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

Pain Management	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

Almont Community Schools
Option 20 HDHP POS 1400 - 100 - Plan B, HQ3, HT6
2023 HDHP Summary of Benefits

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	Retail	*Mail Order*
Prescription Drugs		
Generic	After deductible $15 co-pay	After deductible $30 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 $50 co-pay	After deductible $100 co-pay

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Effective Date:	01/01/23

Contract Type:	**Rates:**
Single	$389.37
Double	$934.49
Family	$1,168.11

This proposal is contingent upon:

* Employer contribution of at least 50% of the single rate.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* No changes in federal, state or other applicable legislation or regulation requiring changes to this proposal.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP Community's right to adjust the SIC assignments as well as the rates in this proposal.
* State regulatory approval of rates.
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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:
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Syriac/Assyrian:

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܗܡܙܡܢܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܢܦܠܚܬ ܡܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܝ 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.

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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).

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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

Almont Community Schools
Option 22 HDHP POS 2000 - 80 - Plan B, HQ3, HT6
2023 HDHP Summary of Benefits

Please note: BIB summary is illustrative
Finalized 2023 BIB summary will be provided once available.

	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	Self Only: $2,000 Family: $4,000	Self Only: $4,000 Family: $8,000
Coinsurance	After deductible 20% coinsurance	After deductible 40% coinsurance
Total Annual Out-of-Pocket Maximum	Self Only: $4,000 Family: $8,000	Self Only: $8,000 Family: $16,000
Physician Office Visits		
Physician Office Visits	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Specialist Office Visit	After deductible 20% coinsurance	After deductible 40% 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	Not Covered
Emergency Care		
Hospital Emergency Room	After deductible 20% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Urgent Care Center	After deductible 20% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Physician's Office	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Medically Necessary Ambulance Services - Ground and Air	After deductible 20% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Hospital Services		
Inpatient Hospital Services	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
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 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Outpatient surgery and nuclear medicine		
Outpatient MRI, MRA, CAT, and PET scans	After deductible 20% coinsurance	After deductible 40% 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 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Diagnostic X-ray	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

Almont Community Schools
Option 22 HDHP POS 2000 - 80 - Plan B, HQ3, HT6
2023 HDHP Summary of Benefits

Please note: BIB summary is illustrative
Finalized 2023 BIB summary will be provided once available.

	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 20% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 20% coinsurance Benefit maximum: up to 60 days per year	Not Covered
Home Health Care	After deductible 20% coinsurance Benefit maximum: up to 60 days per episode per year	Not Covered
Hospice Care	After deductible 20% coinsurance	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Outpatient Mental Health	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 20% coinsurance Benefit maximum: up to 60 visits per condition per year	After deductible 40% coinsurance Benefit maximum: up to 60 visits per condition per year Provider balance bill may apply
Outpatient Habilitative Services - Physical and Occupational Therapy, Applied Behavioral Analysis (ABA) for treatment of Autism Spectrum Disorder and Speech Therapies	After deductible 20% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism	After deductible 40% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism Provider balance bill may apply
Chiropractic Spinal Manipulation/Treatment	After deductible 20% coinsurance Benefit maximum: up to $1500 per person per year	After deductible 20% coinsurance Benefit maximum: up to $1500 per person per year
Durable Medical Equipment	After deductible 20% coinsurance	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 20% coinsurance	Not Covered
Infertility Treatment and Counseling	After deductible 20% coinsurance	Not Covered
Voluntary Termination of Pregnancy	After deductible 20% coinsurance	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	After deductible 20% coinsurance	Not Covered
Oral Surgery	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply

Pain Management	After deductible 20% coinsurance	After deductible 40% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

Almont Community Schools
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	Retail	*Mail Order*
Prescription Drugs		
Generic	After deductible $15 co-pay	After deductible $30 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 $50 co-pay	After deductible $100 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.

Effective Date:	01/01/23

Contract Type:	**Rates:**
Single	$336.19
Double	$806.88
Family	$1,008.59

This proposal is contingent upon:

* Employer contribution of at least 50% of the single rate.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* No changes in federal, state or other applicable legislation or regulation requiring changes to this proposal.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP Community's right to adjust the SIC assignments as well as the rates in this proposal.
* State regulatory approval of rates.
* **PENDING DIFS APPROVAL**

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 ܟܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬ ܠܘܟܘܢ ܬܫܡܫܝܬܐ 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).