



HEALTH PLAN COMMUNITY

Grand Ledge Public Schools

190128 POS 2 (Riders: NA6, NBP6, NCP2, ND17, NE5, NDP8, NEP7, W42, NHA2, NQ3)

2023 POS 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	\$1000/\$2000	\$2000/\$4000
Coinsurance	After deductible 0% coinsurance	After deductible 40% coinsurance
Coinsurance Annual Out-of-Pocket Maximum	None	\$4000/\$8000
Total Annual Out-of-Pocket Maximum	\$7350/\$14700	Unlimited
Physician Office Visits		
Physician Office Visits	\$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	\$30 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: <ul style="list-style-type: none"> • 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	\$35 co-pay - no deductible	\$35 co-pay - no deductible Provider balance bill may apply
Physician's Office	\$30 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 40% coinsurance Provider balance bill may apply
Outpatient Hospital Services		
Outpatient surgery and nuclear medicine	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Outpatient MRI, MRA, CAT, and PET scans	After deductible 0% 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 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



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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 40% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Outpatient Mental Health	\$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	\$30 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 40% 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 40% 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
Voluntary Termination of Pregnancy	Not Covered	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	\$30 co-pay - no deductible	Not Covered
Oral Surgery	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 0% coinsurance	After deductible 40% coinsurance Provider balance bill may apply
Pain Management	\$30 co-pay - no deductible	After deductible 40% coinsurance Provider balance bill may apply



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	Retail	Mail Order
Prescription Drugs		
Generic	\$10 co-pay	\$20 co-pay
Formulary	Brand: \$40 co-pay	Brand: \$80 co-pay
	Brand - Generic Available: \$40 co-pay plus difference in cost between Brand and Generic	Brand - Generic Available: \$80 co-pay plus difference in cost between Brand and Generic
Non-Formulary*	\$80 co-pay	\$160 co-pay
Specialty**	\$80 co-pay	

*Prior Authorization or Step Therapy required.

**Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply.

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
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Contract Type:	Rates:
Single	\$572.66
Double	\$1,375.96
Family	\$1,719.29

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**

