Macomb C.U.S.D. #185
PPO & HDHP Group Health
Summary of Benefits
January 1, 2021

	PPO Plan		QHDHP Plan	
Description	**In-Network (PPO)** www.hfninc.com	**Out-of-Network (OON)**	**In-Network (PPO)** www.hfninc.com	**Out-of-Network (OON)**
Deductible**				
Single	$1500	$3000	$2000	$4000
Family	$3000	$6000	$4000	$8000
Out-of-Pocket (OOP) (excluding ded.)				
Single	$3000	$6000	$4000	$8000
Family	$6000	$12,000	$8000	$16,000
2020 PPACA & IRS Maximum In-Network Out-of-Pockets (includes deductibles, coinsurance OOP, copays and Rx copays/OOP's)	$8,550 Single $17,100 Family	Unlimited	$7,000 Single $14,000 Family	Unlimited
PPO & OON Deductible & Out-of-Pocket*	Not Shared*****	Not Shared*	Not Shared*	Not Shared*
Inpatient and Outpatient Expenses subject to deductible and co-Insurance	80%	60%	85%	65%
Physician Office Visit Copay**				
Primary Care	$30	$60	Deductible & 85%	Deductible & 65%
Specialist	$60	$120	coinsurance apply	coinsurance apply
Emergency Room Copay**	$250	$250	$250	$250
Precertification Required for: Admissions; MRI; CT; Pet scans; and surgeries as specified in 1/1/17 Plan Document	$300 penalty for failure to pre-certify	$300 penalty for failure to pre-certify	$300 penalty for failure to pre-certify	$300 penalty for failure to pre-certify
Preventive Care (see Preventive Services Covered List for additional benefits & more details)				
Annual Physical	**Covered 100%**	$40 copay; 100% up to $500 max.	**Covered 100%**	$40 copay; 100% up to $500 max.
Mammogram & Pap	**Covered 100%**	" "	**Covered 100%**	" "
Cholesterol Screening	**Covered 100%**	" "	**Covered 100%**	" "
Colonoscopy, Sigmoidoscopy, Fecal Occult Based on AMA Guidelines	**Covered 100%**	" "	**Covered 100%**	" "
Preventive Office Visits	**Covered 100%**	" "	**Covered 100%**	" "

Well Baby Care	**Covered 100%**	" "	**Covered 100%**	" "
Immunizations	**Covered 100%**	" "	**Covered 100%**	" "
Prescription Card Copay** Generic/Preferred Brand/Non-Preferred Brand/Specialty	30-day $10/40/80/150 90-day $25/100/200/NA	Not Covered	Deductible applies first and then 30-day $10/30/60/80 90-day $25/75/150/NA	Not Covered

*"Not Shared" means that amounts paid for in-network services and amounts paid for out-of-network services will accumulate toward separate deductible and out-of-pocket limits.

**Deductible and Copays apply only toward IRS/PPACA out-of-pockets.

Other Benefits
Flexible Spending Card is Available
QHDHP participants qualify for a Health Savings Account (HSA).
Working Spouse Policy - spouse's own employer group health plan is primary and the District Plan is secondary
Dependent coverage available to age 26
Services provided by LCSW or MSW overseen by a physician are allowed under Substance Abuse / Mental Health

THIS IS A BRIEF COMPARISON OF SELECTED PROVISIONS. PLEASE REFER TO THE APPROPRIATE SUMMARY PLAN DOCUMENT FOR COMPLETE TERMS AND CONDITIONS.

Monthly Premiums

Description		PPO Health Plan	QHDHP Health Plan
Total Cost	**Single**	$1,105.00	$928.00
	Family	$2,389.00	$2007.00
Certified Employee Contribution	**Single**	$135.00	$135.00
	Family	$1194.50	$1003.50
ESP Employee Contribution	**Single**	$135.00	$135.00
	Family	$1194.50	$1003.50