Macomb Community College – PPO
SUMMARY OF BENEFITS

In-Network benefits are based on the Preferred Provider Organization's approved amount. Out-of-Network benefits are based on the Reasonable and Customary amount. Benefits are determined after any applicable Deductible and Cost Sharing, and are subject to Annual, Lifetime, and Other Maximums, General Exclusions and other applicable limitations.

BENEFITS COULD HAVE SLIGHT MODIFICATION UPON ADOPTION OF PLAN.
IN THE EVENT OF A CHANGE AN ANNOUNCEMENT WILL BE MADE.

		In-Network	Out-of Network
Deductible			
	- Individual	$ 500	$ 1,000
	- Family, embedded	$ 1,000	$ 2,000
"Embedded" = can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Deductible maximum. Claims paid after the Family Deductible is satisfied will have no additional Deductible taken.		In and Out-of-Network Deductibles accumulate separately.	
Cost Sharing	- Individual	$ 2,000 maximum	$ 3,000 maximum
	- Family, embedded	$ 4,000 maximum	$ 6,000 maximum
"Embedded" = can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Cost Sharing maximum. Claims paid after the Family Cost Sharing is satisfied will have no additional Cost Sharing taken.		In and Out-of-Network Cost Sharing accumulate separately	
		In-Network 100%/0%;80%/20%	Out-of-Network 80%/20%;60%/40%
Cost Share Maximum – deductible, medical and Rx copays , cost sharing and out-of-network emergency services apply to the maximum		$6,350 individual	$12,700 family

	In-Network	Out-of-Network
	Plan pays after the Copay and/or Deductible as stated. "100%" = No Copay, No Deductible, and No Cost Sharing.	
CHARGES FOR PREVENTIVE CARE SERVICES		
Preventive Care and Screening Services and Immunizations for children, adolescents and adults that: -- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or -- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or -- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved. ********** Please consult the recommendations and guidelines for age, frequency and other guidelines. Some examples of screening include high blood pressure, breast cancer (mammograms), cervical cancer (PAP), cholesterol, depression, diabetes, colorectal cancer (colonoscopies), and prostate cancer (PSA). Examples of immunizations include HIV, DTP, Hepatitis A, Hepatitis B, HIB, HPV, MMR, and Flu Shots.	100%	60% after Deductible

Macomb Community College – PPO
SUMMARY OF BENEFITS

	In-Network	Out-of-Network
CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY		
Urgent Care Facility	$40	60% after Deductible
Urgent Care Physician	80% after Deductible	60% after Deductible
Emergency Room (Copay waived if admitted to Hospital)	$250 Copay	
Emergency Room Physician	100%	
Ambulance	80% after In-Network Deductible	

CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES)		
Office/Outpatient Visit - Primary Care Physician	$40 Copay	60% after Deductible
Office/Outpatient Visit - Specialist Physician and Mental Health/Chemical Dependency Therapist/Physician	$40 Copay	60% after Deductible
Maternity Physician - Pre-Natal, Delivery, Post-Natal Care	80% after Deductible	60% after Deductible
Inpatient Facility – including Maternity	80% after Deductible	60% after Deductible
Inpatient Physician – Well newborn care	80% after Deductible	60% after Deductible
Inpatient Physician	80% after Deductible	60% after Deductible
Outpatient Facility	80% after Deductible	60% after Deductible
Surgical Care Facility	80% after Deductible	60% after Deductible
Surgeon	80% after Deductible	60% after Deductible
Laboratory, X-Ray, and Advanced Imaging	80% after Deductible	60% after Deductible
Allergy Testing and Therapy	80% after Deductible	60% after Deductible
Allergy Injections	80% after Deductible	60% after Deductible
Voluntary Sterilization – male only	80% after Deductible	60% after Deductible

CHARGES FOR OTHER SERVICES		
Durable Medical Equipment and Prosthetic and Orthotic Appliances	80% after in- network Deductible	80% after in- network Deductible
Chemotherapy	80% after Deductible	60% after Deductible
Radiation Therapy	80% after Deductible	60% after Deductible
Hospice	80% after Deductible	80% after in- network Deductible
Home Health Care	80% after Deductible	80% after in- network Deductible
Physical, Speech, and/or Occupational Therapy – 60 visit combined maximum per calendar year	80% after Deductible	60% after Deductible
Skilled Nursing Facility - Plan Year Maximum = 120 days per calendar year	80% after Deductible	80% after in- network Deductible
Spinal Manipulation 24 visit Maximum per calendar year	$30 Copay	60% after Deductible
Private Duty Nursing	50% after Deductible	50% after in- network Deductible

Women'sPreventiveMedicalBenefits

The benefits outlined below are covered with no cost sharing (deductible, copay, and coinsurance waived) at participating/in-networkprovidersonly, subject to the following:

- Nonparticipating/out-of-network providers will continue to be subject to any applicable deductible, copay, or, coinsurance.

- Supplies and services covered under medical benefits are in place of, not in addition to, those same covered supplies and services under pharmacy OR prescription drug benefits.

MEDICAL SERVICES	
PREVENTIVE CARE TYPE	**WHAT IS COVERED AT IN-NETWORK PROVIDERS**
Injectable contraceptives	Contraceptive injections
Contraceptive devices	Vaginal rings, patch, implants, cervical caps, diaphragms, and IUDs.
Services for devices	Insertion and removal of contraceptive devices.
Sterilization of female	Tubal ligation, as well as the associated charges (anesthesia, labs, etc.) Any applicable exclusion periods continue to apply. Complications of the surgery are subject to standard medical benefits.
Education and training	Education and training on contraceptive methods annually.
Well-woman visits	Preventive care visits for adult women annually.
Breastfeeding pumps	Manual and electric breast pumps per pregnancy when purchased or rented from a licensed provider, or purchased from a retail outlet. Hospital-grade pumps are excluded both under preventive care and regular benefits.
Breastfeeding supplies	Not covered, except those included with a covered breast pump.
Lactation support and counseling	Lactation support and counseling per pregnancy from a licensed provider (in hospital or in office).
Screening for gestational diabetes	Screening for pregnant women between 24 and 28 weeks of gestation, and first prenatal visit for pregnant women at high risk for diabetes.
Human papillomavirus (HPV) test	Screening (no age limit).
Counseling for sexually transmitted infections	Counseling during well-woman visits for all sexually active women annually.
Counseling and screening for HIV	Screening and counseling during well-woman visits for all sexually active women annually.
Counseling and screening for interpersonal & domestic violence	Screening

PHARMACY BENEFITS	
Generic/Preferred Brand/Non-Preferred Brand	$10/$40/$80 Copay
Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 1 Copay	
Mail Order: 90 day supply for eligible maintenance drugs at 1 Copay and non-maintenance drugs at 2 Copays	

Women'sPreventivePharmacy/PrescriptionDrugBenefits

The benefits outlined below are covered with no cost sharing (no deductible, no copay, and no coinsurance) for generics at participating retail pharmacies, participating mail order pharmacies, subject to the following:

- Supplies covered under pharmacy benefits are in place of, not in addition to, the same supplies covered under medical benefits.
- If your group plan does not include pharmacy benefits, the following benefits will be added to the existing plan.
- Only contraceptive methods that are both FDA-approved and prescribed for a woman by her health care provider, even if they are generally available over-the counter (OTC).

PHARMACY	
PREVENTIVE CARE TYPE	**WHAT IS COVERED AT PARTICIPATING PHARMACY**
Oral contraceptives	Generic contraceptive pills.*
Injectable contraceptives	Generic contraceptive injections.*
Contraceptive devices	Vaginal ring, patch, cervical caps, and diaphragm.*
Emergency pregnancy prevention	Emergency pregnancy prevention medication. *
Over-the-counter products	These are covered but require a prescription.

* If a generic exists, preferred/formulary brand contraceptives will remain subject to regular pharmacy plan benefits. However, for any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, the otherwise applicable cost-sharing for the branded or non-preferred brand version will be waived.

* When no generic exists, preferred/formulary brand is covered at no cost. If a generic becomes available, the preferred/formulary brand will no longer be covered under preventive care. However, for any individual al for whom the generic drug (or a b rand name d rug) would be medically inappropriate, as determined by the individuals health care provider, the otherwise applicable cost-sharing for the branded or non-preferred brand version will be waived.

All Benefits Combined **No Annual or Lifetime Dollar Maximums**