

Allen County Schools Health Plan Comparison for 1/1/2021

Benefits	MDHP		HDHP	
	Network	Non-Network	Network	Non-Network
Benefit Period	Calendar Year		Calendar Year	
Dependent Age	26 - Removal End of Month		26 - Removal End of Month	
Lifetime Maximum	Unlimited		Unlimited	
Benefit Period Deductible – Single/Family	\$950 / \$1,900	\$1,900 / \$3,800	\$2,900 / \$5,800	\$5,800 / \$11,600
	Embedded Deductible - On a family contract, no one family member will pay more than a single contract.		Embedded Deductible - On a family contract, no one family member will pay more than a single contract.	
Coinsurance	75%	50%	90%	60%
	<i>(Amount Plan pays <u>after</u> Deductible or Copays, unless noted)</i>		<i>(Amount Plan pays <u>after</u> Deductible or Copays, unless noted)</i>	
Coinsurance Maximum – Single/Family	\$2,500 / \$5,000	\$2,500 / \$5,000	\$2,900 / \$5,800	\$4,300 / \$8,600
	On a family contract, no one family member will pay more than a single contract.		On a family contract, no one family member will pay more than a single contract.	
Out-of-Pocket Maximum (<i>Deductible + Coinsurance ONLY</i>) – Single/Family	\$3,450 / \$6,900	\$4,400 / \$8,800	\$5,800 / \$11,600	\$10,100 / \$20,200
	Medical & Rx copays continue to apply to the ACA statutory maximum of \$8,550 / \$17,100 for 2021 Embedded Out-of-Pocket - On a family contract, no one family member will pay more than a single contract.		Embedded Out-of-Pocket. On a family contract, no one family member will pay more than a single contract.	
Preventive Care	100% No deductible	50% after deductible	100% No deductible	60% after deductible
	Preventive Care Services, when received at network provider, as outlined by Health Care Reform are covered by both plans at 100% without having to meet deductibles or coinsurance. A list of covered services is available through Medical Mutual of Ohio.			
Services with Copays - flat dollar copays do accumulate toward the Out-of-Pocket Maximum.				
Office Visit – PCP (Illness/Injury)	\$25 copay, then 100%. Includes most services performed during that visit. <i>If a surgical procedure is performed in the physician's office a separate copay will be charged in addition to the office visit copay.</i>		90%, after deductible	60%, after deductible
Office Visit -Specialist (Illness/Injury)	\$45 copay, then 100%.	Includes most services performed during that visit.	90%, after deductible	60%, after deductible
Well Child Care Services (Under age 21)	100% No deductible	50% after deductible	100% No deductible	60%, after deductible
Urgent Care Office Visit	\$45 copay, then 100%. Includes most services performed during that visit.		90%, after deductible	60%, after deductible
Emergency use of an Emergency Room	\$85 copay, then 75% after deductible. (\$85 copay is waived if admitted)		90%, after deductible	
Non-Emergency use of an Emergency Room			90%, after deductible	
Inpatient and Outpatient Facility				
Semi-Private Room and Board	75%	50%	90%	60%
Diagnostic Services (Labs, X-rays and Testing)	75%	50%	90%	60%
Surgery	75%	50%	90%	60%
Therapy (Physical, Occupational, Speech)	75%	50%	90%	60%
Additional Services				
Ambulance	75%	50%	90%	60%
Chiropractic Services (26 visits per benefit period)	50%	50%	90%	60%

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	Deductible waived; Not applied to coinsurance limits			
Durable Medical Equipment	75%	50%	90%	60%
Home Healthcare	75%	50%	90%	60%
Hospice	75%	50%	90%	60%
Outpatient Allergy Testing	100% No deductible	50%	90% No deductible	60%
Outpatient Allergy Treatment	75% No deductible	50%	90% No deductible	60%
Bariatric Surgery	not covered	not covered	not covered	not covered
Lasik	not covered	not covered	not covered	not covered
Prescription Drugs	Express Scripts National Preferred Formulary Network		Express Scripts National Preferred Formulary Network	
	<p>Copays apply after separate retail calendar year deductible (\$100/person, \$200/two people, \$300 family) has been met.</p> <p style="text-align: center;">Retail - 30 day supply Generic: \$20 copay Formulary Brand: \$45 copay Non-Formulary Brand: \$70 copay</p> <p style="text-align: center;">Mail Order - 90 day supply Generic: \$40 copay Formulary Brand: \$90 copay Non-Formulary Brand: \$140 copay</p> <p style="text-align: center;">Specialty Drugs - limited to a 30 day supply 20% with a maximum of \$95 Must obtain thru ESI Specialty Pharmacy</p>		<p>Copays apply after benefit period deductible has been met.</p> <p style="text-align: center;">Retail - 30 day supply Generic: \$20 copay Formulary Brand: \$45 copay Non-Formulary Brand: \$70 copay</p> <p style="text-align: center;">Mail Order - 90 day supply Generic: \$40 copay Formulary Brand: \$90 copay Non-Formulary Brand: \$140 copay</p> <p style="text-align: center;">Specialty Drugs - limited to a 30 day supply 20% with a maximum of \$95 Must obtain thru ESI Specialty Pharmacy</p>	

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2021 Monthly Premium Rates Effective Jan. 1, 2021	MDHP Medical & Rx Monthly Rates		HDHP Medical & Rx Monthly Rate	
	SINGLE	FAMILY	SINGLE	FAMILY
	FOR FULLTIME EMPLOYEES			
Total Rate	\$726.12	\$1,799.82	\$645.62	\$1,601.06
Board Contribution	\$675.00	\$1,425.00	\$675.00	\$1,425.00
Employee Contribution	\$51.12	\$374.82	\$0.00	\$176.06
	FOR 3/4 TIME EMPLOYEES			
Total Rate	\$726.12	\$1,799.82	\$645.62	\$1,601.06
Board Contribution	\$506.25	\$1,068.75	\$506.25	\$1,068.75
Employee Contribution	\$219.87	\$731.07	\$139.37	\$532.31
	FOR 1/2 TIME EMPLOYEES			
Total Rate	\$726.12	\$1,799.82	\$645.62	\$1,601.06
Board Contribution	\$337.50	\$712.50	\$337.50	\$712.50
Employee Contribution	\$388.62	\$1,087.32	\$308.12	\$888.56
DENTAL INSURANCE MONTHLY RATES				
	FOR FULLTIME EMPLOYEES			
	SINGLE	FAMILY		
Total Rate	\$102.64	\$102.64		
Board Contribution	\$88.00	\$88.00		
Employee Contribution	\$14.64	\$14.64		
	FOR 3/4 TIME EMPLOYEES			
Total Rate	\$102.64	\$102.64		
Board Contribution	\$66.00	\$66.00		
Employee Contribution	\$36.64	\$36.64		
	FOR 1/2 TIME EMPLOYEES			
Total Rate	\$102.64	\$102.64		
Board Contribution	\$44.00	\$44.00		
Employee Contribution	\$58.64	\$58.64		

VISION (per month):
Employee Only = \$6.78
Employee & Spouse = \$12.90
Employee & Children = \$13.56
Employee & Family = \$19.94

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