Oak Grove School District - 2022 PPO Plan Compare

SMCSIG JPA

Plan Name	United HealthCare PPO Plan 90/60		United HealthCare PPO Plan 70/50	
Eligible Class	All Employees		All Employees	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
General Plan Information				
Annual Deductible/Individual (Not transferable between plans)	$400		$1,000	$2,000
Annual Deductible/Family (Not transferable between plans)	$800		$2,000	$4,000
Coinsurance - Plan Responsibility	90%	60%	70%	50%
Office Visit/Exam	$20 copay	40%, after deductible	$25 copay	50%, after deductible
Outpatient Specialist Visit	$30 copay	40%, after deductible	$25 copay	50%, after deductible
Annual Out-of-Pocket Limit/Individual	$2,000	$4,000	$4,000	$10,000
Annual Out-of-Pocket Limit/Family	$4,000	$8,000	$8,000	$20,000
Pharmacy Deductible	None	None	None	None
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes
Outpatient Services				
Preventive Services				
Adult Periodic Exams with Preventive Tests	No Charge	40%, after deductible	No charge	Not covered
Well-Child Care	No Charge	40%, after deductible	No charge	Not covered
Immunizations	No Charge	40%, after deductible	No charge	Not covered
Well Woman Exams	No Charge	40%, after deductible	No charge	Not covered
Mammograms	No charge	40%, after deductible	No charge	Not covered
Diagnostic X-Ray/Lab Test (Non-Preventive)	No charge	40%, after deductible (outpatient lab testing is not covered)	No charge	50%, after deductible (outpatient lab testing is not covered)
Outpatient Facility Charge	10%, after deductible	40%, after deductible (benefit limited to $760/visit)	30%, after deductible	50%, after deductible (benefit limited to $760/visit)
Occupational/Physical Therapy Services	$20 copay	Not covered	$25 copay	Not covered
Speech Therapy	$20 copay	40%, after deductible	$25 copay	50%, after deductible
Maternity Care				
Pregnancy and Maternity Care (Pre-Natal Care)	No charge	40%, after deductible	No charge	50%, after deductible
Inpatient Hospital Services				
Inpatient Hospitalization	10%, after deductible	40%, after deductible	30%, after deductible	50%, after deductible
Emergency Services				
Emergency Room	$250 copay, no deductible (waived, if admitted)		No charge, after $250 copay (waived, if admitted)	
Ambulance	10%, after deductible	10%, after deductible 40%, after deductible if non-emergency	30%, after deductible	30%, after deductible, 50% if non-emergency
Urgent Care Facility	$50 copay	40%, after deductible	$125 copay	50%, after deductible
Mental Health/Substance Abuse Benefits				
Inpatient Care	10%, after deductible	40%, after deductible	30%, after deductible	50%, after deductible
Outpatient Care	$20 copay	40%, after deductible	$25 copay	50%, after deductible
Prescription Drug Benefits				
Retail (Managed by OptumRX)				
Generic	$7 copay	$7 copay	$7 copay	$7 copay
Brand (Formulary/Preferred)	$20 copay	$20 copay	$20 copay	$20 copay
Brand (Non-Formulary/Non-preferred)	$35 copay	$35 copay	$35 copay	$35 copay
Number of Days Supply	31 days	31 days	31 days	31 days
Mail Order				
Generic	$0 copay	Not Covered	$0 copay	Not Covered
Brand (Formulary/Preferred)	$40 copay	Not Covered	$40 copay	Not Covered
Brand (Non-Formulary/Non-preferred)	$70 copay	Not Covered	$70 copay	Not Covered
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	10%, after deductible	Not covered	30%, after deductible	Not covered
Home Health Care limited to 100 visits per year	10%, after deductible	40%, after deductible (up to $150/visit)	30%, after deductible	50%, after deductible (up to $150/visit)
Skilled Nursing or Extended Care Facility limited 100 days/year	No charge after deductible	No charge after deductible	30%, after deductible	50%, after deductible
Hospice Care	10%, after deductible	40%, after deductible	30%, after deductible	50%, after deductible
Chiropractic Care	$20 copay, up to 24 visits	Not covered	$25 copay, up to 24 visits	Not covered
Acupuncture Care	$20 copay, up to 12 treatments	$20 copay, up to 12 treatments	$25 copay, up to 12 treatments	$25 copay, up to 12 treatments
Infertility - Diagnosis & Treatment, limited to $2,000 per person per lifetime	10%, after deductible	40%, after deductible	30%, after deductible	50%, after deductible
Vision Exam	$20 copay	No Covered	$20 copay, limited to 1 exam every 24 months	$25 copay, limited to 1 exam every 24 months
Hearing - Screening	Covered	Covered	Covered	Covered
Hearing Aid(s)	10%, after deductible, to $2,500	40%, after deductible, to $2,500	30%, after deductible, to $2,500	50%, after deductible, to $2,500
2022 Premium Rates	**Effective January 1, 2022**			
Single	$1,122.92		$1,005.64	
Two-Party	$2,245.85		$2,011.27	
Family	$2,920.25		$2,615.09	

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