Oak Grove School District

2024 PPO Plan Comparison

Carrier	United HealthCare		United HealthCare	
Plan Name	PPO Plan $20 90/60 All Employees		PPO Plan 70/50 All Employees	
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Annual Deductible / Individual (not transferable betweer	$400		$1,000	$2,000
Annual Deductible / Family (not transferable between pl	$800		$2,000	$4,000
Coinsurance	90%	60%	70%	50%
Office Visit / Exam	$20 copay	60%, after deductible	$25 copay	50%, after deductible
Outpatient Specialist Visit	$30 copay	60%, after deductible	$25 copay	50%, after deductible
Annual Out-of-Pocket Maximum / Individual	$2,000	$4,000	$4,000	$10,000
Annual Out-of-Pocket Maximum / Family	$4,000	$8,000	$8,000	$20,000
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes
Outpatient Services				
Preventive Services				
Adult Periodic Exams with Preventive Tests	No Charge	Not Covered	No Charge	Not Covered
Well-Child Care	No Charge	Not Covered	No Charge	Not Covered
Immunizations	No Charge	Not Covered	No Charge	Not Covered
Well Woman Exams	No Charge	Not Covered	No Charge	Not Covered
Mammograms	No Charge	Not Covered	No Charge	Not Covered
Diagnostic X-Ray / Lab Tests (Non-Preventive)	90%, after deductible	60%, after deductible	70%, after deductible	50%, after deductible
Outpatient Surgical Facility	90%, after deductible	60% (benefit limited to $760/visit)	70%, after deductible	50%, after deductible
Occupational/Physical Therapy Services	$20 copay	60%, after deductible	$25 copay	50%, after deductible
Speech Therapy	$20 coapy	60%, after deductible	$25 coapy	50%, after deductible
Maternity Care				
Pregnancy and Maternity Care (Pre-Natal Care)	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Inpatient Hospital Services				
Inpatient Hospitalization	90%, after deductible	60%, after deductible	70%, after deductible	50%, after deductible
Emergency Serivcies				
Emergency Room	$250 copay, waived if admitted		$250 copay, waived if admitted	
Ambulance / Air & Ground	90%, after deductible	90% after deductible (if emergent)	70%, after deductible	70% after deductible (if emergent)
Urgent Care Facility	$50 copay	60%, after deductible	$125 copay	50%, after deductible
Mental Health / Substance Abuse Benefits				
Inpatient Care	90%, after deductible	60%, after deductible	70%, after deductible	50%, after deductible
Outpatient Care	$20 copay	60%, after deductible	$25 copay	50%, after deductible

Oak Grove School District

2024 PPO Plan Comparison Continued

Carrier	United HealthCare		United HealthCare	
Plan Name	PPO Plan $20 90/60 All Employees		PPO Plan 70/50 All Employees	
Benefit Summary	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits				
Prescription Drug Deductible	N/A		N/A	
Prescription Drug Annual Out-of-Pocket Limit (Individual)	None		None	
Prescription Drug Annual Out-of-Pocket Limit (Family)	None		None	
Retain Pharmacy				
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
Number of Days Supply for Mail Order	90 days	N/A	90 days	N/A
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	90%, after deductible	Not Covered	70%, after deductible	Not Covered
Home Health Care	90%, after deductible, up to 100 visits per year	60%, after deductible (up to $150/visit), up to 100 visits per year	70%, after deductible	50%, after deductible
Skilled Nursing or Extended Care Facility	No Charge, after deductible	No Charge, after deductible	70%, after deductible	50%, after deductible
Hospice Care	90%, after deductible	60%, after deductible	70%, after deductible	50%, after deductible
Chiropractic	$20 copay, up to 24 visits	60%, after deductible, up to 24 visits	$25 copay, up to 24 visits / year	50%, after deductible, up to 24 visits / year
Acupuncture	$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	Up to $2,000/lifetime, deductible and coinsurance applies		Up to $2,000/lifetime, deductible and coinsurance applies	
Hearing Screening	Covered	Covered	Covered	Covered
Hearing Aid(s)	90%, after deductible, up to $2,500	60%, after deductible, up to $2,500	70%, after deductible, up to $2,500	50%, after deductible, up to $2,500
Vision Exam	$20 copay (one exam every 24 months)	Not Covered	$25 copay (one exam every 24 months)	Not Covered