PARKWAY SCHOOL DISTRICT
COMPARISON OF MEDICAL BENEFITS
January 1, 2020

BENEFIT	UNITED HEALTH CARE BASE PLAN (OPTION 1) January 1, 2020		UNITED HEALTH CARE PREMIUM PLAN (OPTION 2) January 1, 2020		UNITED HEALTH CARE HIGH DEDUCTIBLE PLAN (HSA) January 1, 2020	
	NETWORK	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**
INPATIENT HOSPITAL **Illness** **Injury** **Nervous/Mental** **Substance Abuse**	90% coverage after Deductible has been met	60% coverage after Deductible has been met *Pre-Service Notification Required*	100% coverage after Deductible has been met	70% coverage after Deductible has been met *Pre-Service Notification Required*	100% coverage after Deductible has been met	70% coverage after Deductible has been met *Pre-Service Notification Required*
OUTPATIENT HOSPITAL **Nervous/Mental** **Substance Use**	90% coverage after Deductible has been met	60% coverage after Deductible has been met *Pre-Service Notification Required*	100% coverage after Deductible has been met	70% coverage after Deductible has been met *Pre-Service Notification Required*	100% coverage after Deductible has been met	70% coverage after Deductible has been met *Pre-Service Notification Required*
EMERGENCY ROOM	$200 Co-pay applies	$200 Co-pay applies	$150 Co-pay applies	$150 Co-pay applies	100% coverage after Deductible has been met	100% coverage after Deductible has been met
	If you are admitted as an inpatient to a hospital directly from the Emergency room within 48 hours of the receiving outpatient Emergency treatment for the same condition, you will not have to pay this copayment. The benefits for an Inpatient Stay in a Hospital will apply instead.		*If you are admitted as an inpatient to a hospital directly from the Emergency room within 48 hours of the receiving outpatient Emergency treatment for the same condition, you will not have to pay this copayment. The benefits for an Inpatient Stay in a Hospital will apply instead.*		*If you are admitted as an inpatient to a hospital directly from the Emergency room within 48 hours of the receiving outpatient Emergency treatment for the same condition, you will not have to pay this copayment. The benefits for an Inpatient Stay in a Hospital will apply instead.*	
URGENT CARE CENTER	$75 per visit for Urgent Care	60% coverage after Deductible has been met	$50 per visit for Urgent Care	70% coverage after Deductible has been met	100% coverage after Deductible has been met	100% coverage after Deductible has been met
	In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.		*In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.*			
TRANSPLANT	90% coverage after Deductible has been met Services must be performed at a Designated Facility. *Pre-Service Notification Required*	**No coverage available**	100% coverage after Deductible has been met Services must be performed at a Designated Facility. *Pre-Service Notification Required*	**No coverage available**	100% coverage after Deductible has been met Services must be performed at a Designated Facility. *Pre-Service Notification Required*	**No coverage available**
PHYSICIAN SERVICES **Surgical Services** **Medical Services**	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
PHYSICIAN - OFFICE **Primary Care** **Specialist**	100% after you pay a $25 Copayment per visit. 100% after you pay a $50 Copayment per visit.	60% coverage after Deductible has been met	100% after you pay a $20 Copayment per visit. 100% after you pay a $30 Copayment per visit.	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
INJECTIONS **Allergy Injections** **Other injections Outpatient**	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met

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	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK
OUTPATIENT DIAGNOSTIC **Lab Services** **Radiology Services**	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
OUTPATIENT THERAPY **Chemotherapy** **Radiation Therapy**	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
REHABILITATION SERVICES **Physical Therapy** **Occupational Therapy** **Speech Therapy** **Pulmonary Therapy** **Cardiac Rehabilitation** **Post Cochlear Therapy** **Habilitatitve Services**	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
	Any combination of rehabilitation services is limited to 60 visits per		*Any combination of rehabilitation services is limited to 60 visits per*		*Any combination of rehabilitation services is limited to 60 visits per*	
AMBULANCE	90% coverage after Deductible has been met	90% coverage after Deductible has been met	100% coverage after Deductible has been met	100% coverage after Deductible has been met	100% coverage after Deductible has been met	100% coverage after Deductible has been met
	Pre-Service Notification Required for Non-Emergency Ambulance		*Pre-Service Notification Required for Non-Emergency Ambulance*		*Pre-Service Notification Required for Non-Emergency Ambulance*	
SKILLED NURSING FACILITY	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
	Limited to 60 visits per year		*Limited to 60 visits per year*		*Limited to 60 visits per year*	
HOME HEALTH CARE	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
	Limited to 60 visits per year		*Limited to 60 visits per year*		*Limited to 60 visits per year*	

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	NETWORK	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**
OUTPATIENT SURGERY	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
CHIROPRACTIC **Manipulative Therapy**	100% after you pay a $25 Copayment per visit.	60% coverage after Deductible has been met	100% after you pay a $20 Copayment per visit.	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
	Limited to 30 visits per year		*Limited to 30 visits per year*		*Limited to 30 visits per year*	
PREVENTIVE CARE SERVICES	100% Deductible does not apply	60% coverage after Deductible has been met	100% subject to applicable limitations	70% of covered expenses after Deductible to out of pocket maximum, then 100%	100% subject to applicable limitations	70% of covered expenses after Deductible to out of pocket maximum, then 100%
DURABLE MEDICAL EQUIPMENT	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met
OTHER ELIGIBLE SERVICES	90% coverage after Deductible has been met	60% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met	100% coverage after Deductible has been met	70% coverage after Deductible has been met

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	NETWORK	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**	**NETWORK**	**OUT OF NETWORK**
DEDUCTIBLE	$650 Individual $1,300 Family	$2,000 Individual $4,000 Family	$500 Individual $1,000 Family	$1,000 Individual $2,000 Family	$2,800 Individual $5,600 Family	$5,000 Individual $10,000 Family
OUT OF POCKET MAXIMUM	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$1,500 Individual $3,000 Family	$4,000 Individual $8,000 Family	$2,800 Individual $5,600 Family	$8,000 Individual $16,000 Family
	Medical Copayments, Coinsurance, and Deductibles accumulate toward Out-of-Pocket Maximum		Medical Copayments, Coinsurance, and Deductibles accumulate toward Out-of-Pocket Maximum		Coinsurance and Deductibles accumulate toward Out-of-Pocket Maximum	
MEDICAL LIFETIME MAXIMUM	Unlimited		Unlimited		Unlimited	
PRESCRIPTION DRUGS RETAIL DRUG OUTLET						
Prescription Drug Card Program Generic Drugs Other Prescription Drugs (Including Brand-Name Drugs)	100% after $12 copay for generic brand, or after $40 copay for Preferred drugs and $60 copay for Non-Preferred Drugs.		100% after $12 copay for generic brand, or after $35 copay for Preferred drugs and $55 copay for Non-Preferred Drugs.		Applied to Deductible Zero Out of Pocket after Deductible is met.	
PRESCRIPTION DRUGS MAIL IN DRUGS (3 MONTH SUPPY)						
Prescription Drug Card Program Generic Drugs Other Prescription Drugs (Including Brand-Name Drugs) Mail In Drugs (3 Months Supply)	100% after $24 copay for generic brand, or after $80 copay for Preferred drugs and $120 copay for Non-Preferred Drugs.		100% after $24 copay for generic brand, or after $70 copay for Preferred drugs and $110 copay for Non-Preferred Drugs.		Applied to Deductible Zero Out of Pocket after Deductible is met.	

GLOSSARY	DEFINITION
NETWORK	Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator
GENERIC DRUGS	-generally these are the least expensive and are the most cost effective for both you and the plan.
PREFERRED BRAND DRUGS	-generally these drugs do not have a generic equivalent or may be a less-expensive, but equally effective, alternative to its Non-Preferred counterpart.
NON-PREFERRED BRAND DRUGS	-generally these drugs have either a generic or Preferred Brand alternative available. These drugs tend to be the most expensive drugs for both you and the plan.
NOTE :	In the event of any inconsistency between this summary and the actual Plan Document for each plan, the provisions of the Plan Document shall apply.