

**PARKWAY SCHOOL DISTRICT  
COMPARISON OF MEDICAL BENEFITS  
January 1, 2022**

BENEFIT	UNITED HEALTH CARE BASE PLAN (OPTION 1) January 1, 2022		UNITED HEALTH CARE PREMIUM PLAN (OPTION 2) January 1, 2022		UNITED HEALTH CARE HIGH DEDUCTIBLE PLAN (HSA) January 1, 2022	
	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK
	<b>INPATIENT HOSPITAL</b>					
<b>Illness Injury Nervous/Mental Substance Abuse</b>	90% coverage after Deductible has been met	60% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>	100% coverage after Deductible has been met	70% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>	100% coverage after Deductible has been met	70% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>
<b>OUTPATIENT HOSPITAL</b>						
<b>Nervous/Mental Substance Use</b>	90% coverage after Deductible has been met	60% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>	100% coverage after Deductible has been met	70% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>	100% coverage after Deductible has been met	70% coverage after Deductible has been met  <i>Pre-Service Notification Required</i>
<b>EMERGENCY ROOM</b>	\$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
	<i>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.</i>		<i>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.</i>		<i>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.</i>	
<b>URGENT CARE CENTER</b>	\$75 per visit for Urgent Care  <i>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.</i>	60% coverage after Deductible has been met	\$50 per visit for Urgent Care  <i>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.</i>	70% coverage after Deductible has been met	100% coverage after Deductible has been met	100% coverage after Deductible has been met
<b>TRANSPLANT</b>	90% coverage after Deductible has been met  Services must be performed at a Designated Facility.  <i>Pre-Service Notification Required</i>	<b>No coverage available</b>	100% coverage after Deductible has been met  Services must be performed at a Designated Facility.  <i>Pre-Service Notification Required</i>	<b>No coverage available</b>	100% coverage after Deductible has been met  Services must be performed at a Designated Facility.  <i>Pre-Service Notification Required</i>	<b>No coverage available</b>
<b>PHYSICIAN SERVICES</b>						
<b>Surgical Services Medical Services</b>	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
<b>PHYSICIAN - OFFICE</b>						
<b>Primary Care Specialist</b>	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
<b>INJECTIONS</b>						
<b>Allergy Injections Other injections Outpatient</b>	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
<b>OUTPATIENT DIAGNOSTIC</b>  <b>Lab Services</b> <b>Radiology Services</b>	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
<b>OUTPATIENT THERAPY</b>  <b>Chemotherapy</b> <b>Radiation Therapy</b>	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
<b>REHABILITATION SERVICES</b>  <b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b> <b>Pulmonary Therapy</b> <b>Cardiac Rehabilitation</b> <b>Post Cochlear Therapy</b> <b>Habilitatitve Services</b>	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
	<i>Any combination of rehabilitation services is limited to 60 visits per</i>		<i>Any combination of rehabilitation services is limited to 60 visits per</i>		<i>Any combination of rehabilitation services is limited to 60 visits per</i>	
<b>AMBULANCE</b>	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
	<i>Pre-Service Notification Required for Non-Emergency Ambulance</i>		<i>Pre-Service Notification Required for Non-Emergency Ambulance</i>		<i>Pre-Service Notification Required for Non-Emergency Ambulance</i>	
<b>SKILLED NURSING FACILITY</b>	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
	<i>Limited to 60 visits per year</i>		<i>Limited to 60 visits per year</i>		<i>Limited to 60 visits per year</i>	
<b>HOME HEALTH CARE</b>	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
	<i>Limited to 60 visits per year</i>		<i>Limited to 60 visits per year</i>		<i>Limited to 60 visits per year</i>	

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	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK
	<b>OUTPATIENT SURGERY</b>	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
<b>CHIROPRACTIC Manipulative Therapy</b>	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
	<i>Limited to 30 visits per year</i>		<i>Limited to 30 visits per year</i>		<i>Limited to 30 visits per year</i>	
<b>PREVENTIVE CARE SERVICES</b>	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%
<b>DURABLE MEDICAL EQUIPMENT</b>	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
<b>OTHER ELIGIBLE SERVICES</b>	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
	<b>DEDUCTIBLE</b>	\$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
<b>OUT OF POCKET MAXIMUM</b>	\$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	
<b>MEDICAL LIFETIME MAXIMUM</b>	Unlimited		Unlimited		Unlimited	
<b>PRESCRIPTION DRUGS RETAIL DRUG OUTLET</b>	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.	
<b>PRESCRIPTION DRUGS MAIL IN DRUGS (3 MONTH SUPPLY)</b>	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.	
<b>GLOSSARY</b>	<b>DEFINITION</b>					
<b>NETWORK</b>	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					
<b>GENERIC DRUGS</b>	-generally these are the least expensive and are the most cost effective for both you and the plan.					
<b>PREFERRED BRAND DRUGS</b>	-generally these drugs do not have a generic equivalent or may be a less-expensive, but equally effective, alternative to its Non-Preferred counterpart.					
<b>NON-PREFERRED BRAND DRUGS</b>	-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.					
<b>NOTE :</b>	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.					