Keenan®

Moraga School District
2024 PPO Plans/Rates

Carrier	United HealthCare			
Plan Name	PPO Modified Select Plus - 80/60		PPO Modified Select Plus - 70/50	
General Plan Information	**PPO Providers**	**Non-Network Providers**	**PPO Providers**	**Non-Network Providers**
Annual Deductible - Single/Family	$1,000/$2,000		$1,000/$2,000	$2,000/$4,000
Coinsurance	80%	60%	70%	50%
Office Visit PCP/Specialist	$25 /$35 copay	40% after deductible	$25 / $25 copay	50% after deductible
Annual OOP - Individual/Family	$4,000/$8,000	$7,000/$14,000	$4,000/$8,000	$10,000/$20,000
Outpatient Services				
Well-Child Care	No charge	40% after deductible	No charge	Not Covered
Adult Periodic Exam with Preventive Tests	No charge	40% after deductible	No charge	Not Covered
Pregnancy & Maternity Care (Pre-Natal Care)	No charge	40% after deductible	No charge	50% after deductible
Diagnostic X-ray and Lab	No charge	Lab- Not Covered, X-Ray- 40% after deductible	No charge	Lab- Not available X-Ray 50% after deductible
Outpatient Rehab Therapy Services	$25 copay	Not Covered for physical therapy, occupational therapy, and manipulative treatments. 40% after deductible for all other therapies	$25 copay	Not Covered for physical therapy, occupational therapy, and manipulative treatments. 50% after deductible for all other therapies
Outpatient Surgery	20% after deductible	40% after deductible, OON- Limits apply	30% after deductible	50% after deductible, OON- Limits apply
Inpatient Hospital Services				
Semi-Private Room & Board; including services & supplies	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Emergency Services				
Emergency Room	$250 copay per visit	$250 copay per visit	$250 copay (waived if admitted)	$250 copay (waived if admitted)
Urgent Care	$25 copay	40% after deductible	$125 copay	50% after deductible
Mental Health & Substance Abuse Benefits				
Inpatient Care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Outpatient Care	$25 copay	40% after deductible	$25 copay	50% after deductible
Prescription Drug Benefits				
Generic	$10 copay	$10 copay	$7 copay	$7 copay
Brand (Formulary/Preferred)	$30 copay	$30 copay	$20 copay	$20 copay
Brand (Non-Formulary/Non-Preferred)	$60 copay	$60 copay	$35 copay	$35 copay
Specialty	Matches Retail In-Network	In-Network Only	Matches Retail In-Network	In-Network Only
Number of Days Supply	31 days	31 days	31 days	31 days
Mail Order				
Generic	$20 copay	$20 copay	$0 copay	$0 copay
Brand (Formulary/Preferred)	$60 copay	$60 copay	$40 copay	$40 copay
Brand (Non-Formulary/Non-Preferred)	$120 copay	$120 copay	$70 copay	$70 copay
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days
Other Services and Supplies				
Durable Medical Equipment	20% after deductible	Not available	30% after deductible	Not available
Home Health Care	20% after deductible	40%, up to $150 per visit after deductible	30% after deductible	50%, up to $150 per visit after deductible
Chiropractic	$25 copay up to 24 visits	Not Covered	$25 copay up to 24 visits	Not available
Acupuncture Services	$25 copay, benefit is 12 visits combined in and out of network	$25 copay, benefit is 12 visits combined in and out of network	$25 copay, benefit is 12 visits combined in and out of network	$25 copay, benefit is 12 visits combined in and out of network
Premium Rates - Monthly				
Employee Only	$1,533.49		$1,568.43	
Employee + One	$3,065.39		$3,136.85	
Employee + Two or More	$3,985.15		$4,078.58	