



# Oregon School District

## HEALTH COVERAGE OPTIONS

Effective: 7/1/2023

Carrier		
<b>Provider Network</b>	GHC HMO	GHC PPO
<b>Deductible</b>		
In-Network (Single / Family)	\$500 / \$1,000	\$500 / \$1,000
Out-of-Network (Single / Family)	Not Covered	\$1,000 / \$2,000
<b>Coinsurance</b>		
In-Network	100%	100%
Out-of-Network	Not Covered	90%
<b>Deductible / Coinsurance Limit</b>	Includes Deductible and Coinsurance	Includes Deductible and Coinsurance
In-Network (Single / Family)	\$500 / \$1,000	\$500 / \$1,000
Out-of-Network (Single / Family)	Not Covered	\$2,000 / \$4,000
<b>Out-of-Pocket Max</b>	<i>Includes Deductible, Coinsurance and Medical Copays</i>	<i>Includes Deductible, Coinsurance and Medical Copays</i>
In-Network (Single / Family)	\$4,600 / \$9,200	\$4,600 / \$9,200
Out-of-Network (Single / Family)	Not Covered	\$4,600 / \$9,200
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Office Visits</b>		
In-Network	\$25 Copay	\$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
<b>GHCMYChart Video Visit</b>		
In-Network	\$25 Copay	\$25 Copay
<b>Specialist</b>		
In-Network	\$25 Copay	\$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
<b>Routine/Preventive Care</b>		
In-Network	100% Coverage	100% Coverage
Out-of-Network	Not Covered	Ded, 90% Coins
<b>Inpatient Hospital Services</b>		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
<b>Outpatient Hospital Services</b>		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
<b>MRI / PET / CAT Scans</b>		
In-Network	\$150 Copay	\$150 Copay
Out-of-Network	N/A	Ded, 90% Coins
<b>Mental Health / Behavioral Health Services</b>		
<b>Outpatient</b>		
In-Network	\$25 Copay	\$25 Copay
Out-of-Network	Not Covered	Ded, 90% Coins
<b>Inpatient</b>		
In-Network	Ded, 100% Coins	Ded, 100% Coins
Out-of-Network	Not Covered	Ded, 90% Coins
<b>Emergency Room</b>		
In-Network	\$100 Copay	\$100 Copay
Out-of-Network	\$100 Copay	\$100 Copay
<b>Prescription Drugs - In-Network</b>		
	<i>Prescription Max Out of Pocket</i>	<i>Prescription Max Out of Pocket</i>
	<i>\$2,000 Single / \$4,000 Family</i>	<i>\$2,000 Single / \$4,000 Family</i>
Tier 1 / Tier 2 / Tier 3	\$10 / \$30 / \$60	\$10 / \$30 / \$60
<b>Total Monthly Premium</b>		
Employee	\$783.87	\$783.87
Family	\$1,763.71	\$1,763.71

This constitutes only a summary of the Health plan involved. The actual contract or plan document must be consulted to determine the governing contractual provisions, limitations, or exclusions. There is no guarantee, expressed or implied by USI Insurance Services or vendors of plan provisions or level of payments.