# MAPLETON PUBLIC SCHOOLS
## July 1, 2021 - June 30, 2022
## MEDICAL INSURANCE RATES

This is only for illustrative and summary purposes. The contents of this summary are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted on the following pages. The benefits in this summary may only be available if required plan procedures are followed (e.g., use of specific providers or facilities).

| Summary of Covered Benefits | Traditional HMO | | | Deductible HMO | | |
|---|---|---|---|---|---|---|
| | Primary Care | Preventive* | Specialist | Primary Care | Preventive* | Specialist |
| Physician Copayment | $30 | $0 | $80 | $25 | $0 | $45 |
| Deductible Applies First | $0 (Individual)<br>$0 (Family) | | | $1,000 (Individual)<br>$3,000 (Family) | | |
| Coinsurance (paid by individual) | 0% Coinsurance (in most instances) | | | 20% Coinsurance | | |
| Out of Pocket Maximum | $4,000 (Individual)<br>$10,000 (Family) | | | $3,000 (Individual)<br>$6,000 (Family) | | |
| Is Deductible included in OOP Max? | Yes | | | Yes | | |
| Maternity Copayment (Office) | No Charge - prenatal/postnatal care | | | 20% Coinsurance - prenatal/postnatal care | | |
| Hospital Copayment | $750 Copay | | | Deductible and Coinsurance | | |
| Outpatient Hospital | Ambulatory Surgical Center: $100 Copay<br>Outpatient Hospital: $400 Copay | | | Ambulatory Surgical Center: $400 Copay<br>Outpatient Hospital: Deductible and Coinsurance | | |
| Lab/X-rays | $100 Copay per test for MRI, CT, PET scans | | | Deductible and Coinsurance | | |
| | Lab and X-ray - No Charge | | | Lab - No Charge**<br>X-rays - 20% Coinsurance | | |
| Emergency Room | $250 | | | Deductible and Coinsurance | | |
| Emergency Transportation | 20% Coinsurance up to $500 per trip | | | 20% Coinsurance up to $500 per trip*** | | |
| Prescriptions | Generic: Retail $15 - Mail $30<br>Brand: Retail $40 - Mail $80<br>Non-Preferred: Retail $60 - Mail $120<br>Specialty****: 20% coins. to $250 | | | | | |
| Skilled Nursing Care | $750 Copay per admission (Limited to 100 days per year) | | | 20% Coinsurance (Limited to 100 days per year) | | |
| Vision | $150 credit every 2 years | | | $150 credit every 2 years | | |
| Chiropractic | $30 Copay (20 visits per year) | | | $25 Copay (20 visits per year) | | |
| Out of Network Benefits | Emergency Only | | | Emergency Only | | |
| **Coverage Tiers** | **Semi-Monthly Premium Paid by Employee** | | | **Semi-Monthly Premium Paid by Employee** | | |
| Employee Only | $76.00 | | | $40.50 | | |
| Employee + Spouse | $291.00 | | | $216.00 | | |
| Employee + Child(ren) | $262.00 | | | $191.00 | | |
| Employee + Family | $428.00 | | | $324.00 | | |

*Preventive services defined on Healthcare.gov not subject to deductible. Please note: DHMO Primary care and Specialist Visits are not subject to deductible.

** DHMO, Lab 20% coinsurance applies if performed in the outpatient department of a hospital.

*** DHMO, Emergency Transportation not subject to deductible.

****Specialty Drug per drug dispensed retail and mail order prescriptions.

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