MAPLETON PUBLIC SCHOOLS
July 1, 2023 - June 30, 2024
MEDICAL INSURANCE RATES

Summary of Covered Benefits	Traditional HMO	Deductible HMO
Physician/ Primary Copayment	$30	$25
Specialist Copayment	$80	$45
Annual Preventive Care/Screening	No Charge	No Charge
Urgent Care	$50 Copay per visit	$45 Copay per visit
Contract Year Deductible	$0 (Individual)	$1,000 (Individual)
	$0 (Family)	$3,000 (Family)
Out of Pocket Maximum	$4,000 (Individual)	$3,000 (Individual)
(Includes deductible, coinsurance, and copays)	$10,000 (Family)	$6,000 (Family)
Is Deductible included in OOP Max?	Not applicable	Yes
Coinsurance (paid by individual)	0% Coinsurance (in most instances)	20% Coinsurance after the deductible
Maternity Copayment (Office)	No Charge - prenatal/postnatal care	20% Coinsurance - prenatal/postnatal care
Hospital Copayment	$750 Copay per visit	Deductible and 20 % Coinsurance
Outpatient Hospital	Ambulatory Surgical Center: $100 Copay	Ambulatory Surgical Center: $500 Copay
	Outpatient $400 Copay	Outpatient 20% Coinsurance
Diagnostic Lab and X-Ray	X-ray and Lab - No Charge	X-ray 20% Coinsurance - Lab No Charge
Imaging (CT/PET scans, MRI's)	$100 Copay per test	20% Coinsurance after the deductible
Emergency Room	$250	Deductible and Coinsurance
Emergency Transportation	20% Coinsurance up to $500 per trip	20% Coinsurance up to $500 per trip***
Prescription Copays are the same for both plans	Generic/Retail Copay	$15 $30 Mail order
	Brand/Retail Copay	$40 $80 Mail order $60
	Non-Preferred Drugs Retail Copay	$60 $120 Mail order
Specialty Drugs	20% coinsurance up to $250 per drug dispensed retail. Specialty Drug per drug dispensed retail and mail order prescriptions.	
Skilled Nursing Care	100% (Limited to 100 days per year)	20% Coinsurance after the deductible (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)
Coverage Tiers	*Employee Cost Semi-monthly*	*Employee Cost Semi-monthly*
Employee Only	$ 86.79	$ 45.43
Employee + Spouse	$318.18	$231.00
Employee + Child(ren)	$287.57	$205.97
Employee + Family	$466.02	$345.32

*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.