



MAPLETON PUBLIC SCHOOLS

July 1, 2024 - June 30, 2025

MEDICAL INSURANCE RATES/PART-TIME

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)
	\$10,000 (Family)	\$6,000 (Family)
Is Deductible included in OOP Max?	Yes	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	\$190.90	\$143.34
Employee + Spouse	\$495.84	\$395.58
Employee + Child(ren)	\$460.86	\$367.02
Employee + Family	\$706.51	\$567.70

*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.