



MAPLETON PUBLIC SCHOOLS
July 1, 2024 - June 30, 2025
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 (Includes deductible, coinsurance, and copays) | \$4,000 (Individual) | \$3,000 (Individual) |
| | \$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 |
| <i>If both spouses work for the district contact the Benefit Specialist for rates</i> | | |
| Employee Only | \$103.71 | \$ 56.15 |
| Employee + Spouse | \$355.22 | \$254.96 |
| Employee + Child(ren) | \$322.42 | \$228.58 |
| Employee + Family | \$517.44 | \$378.63 |

*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.



The Plus Benefit Added to HMO & DHMO Plans

If you want to see a provider outside the Kaiser network (non-Plan Provider), your Plus Benefit allows you access to certain benefits, see below.

| Summary of Covered Benefits | HMO Plus Benefits | DHMO Plus Benefits | |
|---|--|--|-------------------------------------|
| Maximum Benefit per Individual per Contract Year | 10 combined total visits/services | 10 combined total visits/services | |
| Primary Care Visit | \$40 copay | \$35 copay | |
| | | 30% coinsurance for procedures received during visit | |
| Specialty Care Visit | \$90 copay | \$55 copay | |
| | | 30% coinsurance for procedures received during visit | |
| Office Administered Drugs | Injectable birth control and IUDs are covered | | |
| Laboratory | 10% coinsurance | 30% coinsurance | |
| | For services at a non-Plan Office or Free-Standing Facility (each Laboratory service provider per day is considered a visit) | | |
| X-Ray (Diagnostic Only) | 10% coinsurance | 30% coinsurance | |
| | (Each X-Ray is considered a visit) | | |
| Special Procedures: MRI/CT/PET/Nuclear Medicine | Not Covered | | |
| Mental Health Outpatient | \$40 copay | \$35 copay | |
| | | 30% coinsurance for procedures received during an office visit | |
| Chemical Dependency Outpatient | \$40 copay | \$35 copay | |
| | | 30% coinsurance for procedures received during an office visit | |
| Physical, Occupational, Speech Therapy (Outpatient) | \$40 copay | \$35 copay | |
| | | At a Non-Plan Office or Free-Standing Site | |
| Preventive and Well-Child Care | No charge | | |
| Durable Medical Equipment (Provided by office, Supplemental only) | 10% coinsurance | 30% coinsurance | |
| | Prosthetic arms and legs are not covered. | | |
| | (Each item dispensed during office visit is considered a visit) | | |
| Prescription Drugs | Prescription drugs from non-Kaiser Permanente physicians will be covered when filled at a Kaiser Permanente pharmacy at your regular Plan prescription drug cost share, subject to the Kaiser Permanente formulary. This will not count toward the combined total visit limit. | | |
| | When filled in a non-Kaiser Permanente pharmacy, retail prescription drugs are not covered | | |
| | Generic Drugs: Not covered | Brand Drugs: Not covered | Non-Preferred Drugs: Not covered |