



**MAPLETON PUBLIC SCHOOLS July 1, 2026 - June 30, 2027 MEDICAL INSURANCE RATES**

Summary of Covered Benefits	KP-HMO 30	KP-DHMO1500	United Healthcare PPO5
Physician/ Primary Copayment	\$30	\$40	\$45
Specialist Copayment	\$45	\$40	\$45
Telemedicine	Covered 100%	Covered 100%	Covered 100%
Annual Preventive Care/Screening	No Charge	No Charge	No Charge
Urgent Care	\$50 Copay per visit	\$40 Copay per visit	\$75 Copay per visit
Plan Year Deductible	\$0 (Individual)	\$1,500 (Individual)	\$2,500 (Individual)
	\$0 (Family)	\$3,000 (Family)	\$5,000 (Family)
Out of Pocket Maximum (Includes deductible, coinsurance, and copays)	\$4,000 (Individual)	\$4,000 (Individual)	\$4,500 In / \$9,000 Out (Individual)
	\$8,000 (Family)	\$8,000 (Family)	\$9,000 In / \$18,000 Out (Family)
Is Deductible included in OOP Max?	Not applicable	Yes	Yes
Coinsurance (paid by individual)	In Network	In Network	20% In / 40% Out
Maternity Benefits	Office Visits: No Charge  Childbirth/Delivery Services: No Charge  Childbirth/Delivery Facility: \$750/admission	Office Visits: 20%Coinsurance up to OOPM  Childbirth/Delivery Services: 20%Coinsurance up to OOPM  Childbirth/Delivery Facility: 20% Coinsurance up to OOPM	Office Visits: No Charge  Childbirth/Delivery Services: 20%Coinsurance up to OOPM  Childbirth/Delivery Facility: 20% Coinsurance up to OOPM
Inpatient Hospital	\$750 Copay per admission	Deductible + 20% Coinsurance to OOPM	Deductible + 20% Coinsurance to OOPM (40% Out-of-Network)
Outpatient Hospital	Ambulatory Surgical Center: \$250 Copay	Ambulatory Surgical Center: \$500 Copay	Deductible + 20% Coinsurance to OOPM (40% Out-of-Network)
	Outpatient \$500 Copay	Outpatient Deductible + 20% Coinsurance to OOPM	
Diagnostic Lab and X-Ray	X-ray and Lab - No Charge	X-ray: Deductible + 20% Coins. To OOPM Lab: No Copay	X-ray: \$45 in office, outpatient subject to ded. Lab: \$45 copay
Imaging (CT/PET scans, MRI's)	\$200 Copay per test	Deductible + 20% Coinsurance to OOPM	Deductible + 20% Coinsurance to OOPM
Emergency Room	\$250 copay	Deductible + 20% Coinsurance to OOPM	Deductible + 20% Coinsurance to OOPM (40% Out-of-Network)
Emergency Transportation	20% Coinsurance up to \$500/trip	Deductible + 20% Coinsurance to OOPM	Deductible + 20% Coinsurance to OOPM (40% Out-of-Network)
Prescription Copays	Generic \$20 Mail Order 2x	Generic \$20 Mail Order 2x	Generic \$20 Mail Order 2x
	Brand \$40 Mail Order 2x	Brand \$40 Mail Order 2x	Brand \$40 Mail Order 2x
	Non-Preferred Drugs \$60 Mail Order 2x	Non-Preferred Drugs \$60 Mail Order 2x	Non-Preferred Drugs \$60 Mail Order 2x
Specialty Drugs	20% coinsurance up to \$250 per drug dispensed retail.	20% coinsurance up to \$250 per drug dispensed retail.	N/A
Vision	Visit: \$30 Copay Test: 20% Coinsurance (frames/lenses/contacts not covered)	Visit: \$40 Copay Test: 20% Coinsurance (frames/lenses/contacts not covered)	1 Exam/Refraction per calendar year covered 100% (frames/lenses/contacts not covered)
Chiropractic	\$30 Copay (20 visits per accumulation period)	\$40 Copay (20 visits per accumulation period)	\$45 Copay (20 visits per year)
<b>Coverage Tiers</b>	<b>Employee Cost Semi-monthly (full-time)</b>		
	<b>If both spouses work for the district contact the Benefit Specialist for rates</b>		
Employee Only	\$141.17	\$60.67	\$82.67
Employee + Spouse	\$458.50	\$289.05	\$335.55
Employee + Child(ren)	\$378.75	\$229.25	\$270.75
Employee + Family	\$632.13	\$407.13	\$468.63

THIS BENEFIT SUMMARY IS FOR ILLUSTRATION PURPOSES ONLY. Proposal is not to be construed as an exact or complete analysis of the policies nor as legal evidence of insurance. \*Amounts could change once input into the system due to rounding when full monthly premiums are entered