

Jefferson City School District

HDHP 003/004 Summary of benefits – Medical

Administered by UMR

Covered services	In-network providers	Out-of-network providers
Calendar year deductible		
Per person	\$1,800	\$3,600
Family	\$3,600	\$7,200
Maximum out-of-pocket expense		
Per person	\$4,500	\$9,000
Family	\$9,000	\$18,000
Primary care physician (PCP) office visits	\$25 copay after Deductible	Deductible; plan pays 70%
Specialist office visits	\$50 copay after Deductible	Deductible; plan pays 70%
Physician office services	Deductible; plan pays 90%	Deductible; plan pays 70%
Urgent care visit	\$50 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Emergency room (ER)	In-Network Deductible; plan pays 90%	
Ambulance	In-Network Deductible; plan pays 90%	
Durable medical equipment	Deductible; plan pays 90%	Deductible; plan pays 70%
Outpatient diagnostic X-ray and lab work	Deductible; plan pays 90%	Deductible; plan pays 70%
Outpatient hospital services	Deductible; plan pays 90%	Deductible; plan pays 70%
Inpatient hospital services	\$100 copay after Deductible; plan pays 90%	Deductible; plan pays 70%
Physical therapy	\$50 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Speech, hearing and occupational therapy	\$50 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Teladoc-General Medicine	\$15 Copay; Deductible waived	
Teladoc-Dermatology	\$15 Copay; Deductible waived	
Teladoc-Behavioral Health	\$15 Copay; Deductible waived	
Preventive/routine exams	100%; deductible waived	No Benefit
Preventive/routine Immunizations	100%; deductible waived	No Benefit
Preventive/routine Lab & X-rays	100%; deductible waived	No Benefit
Preventive/routine Mammograms	100%; deductible waived	No Benefit
Preventive/routine pap smear	100%; deductible waived	No Benefit
Preventive/routine prostate cancer screening	100%; deductible waived	No Benefit
Preventive/routine colonoscopy, sigmoidoscopy & similar procedures	100%; deductible waived	No Benefit
Preventive/routine hearing exams	100%; deductible waived	No Benefit
Women's preventive health care	100%; deductible waived	No Benefit

UMR customer service: 1-800-826-9781 [umar.com](https://www.umar.com)

Submit claims to: UMR P.O. Box 30541, Salt Lake City, UT 84130-0541

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.



Jefferson City School District

HDHP 003/004 Summary of benefits – Pharmacy

Administered by RxBenefits, Inc. and OptumRx

Accumulations

Deductible Non-Embedded	\$1,800 Individual / \$3,600 Family
Maximum Out of Pocket Embedded	\$4,500 Individual / \$9,000 Family

The plan year Deductible applies to pharmacy and medical claims. One member or any combination of family members can meet the family Deductible. Once met, your covered prescriptions are subject to the copays above. Generic Dispense as Written policy does not apply to the Deductible. The Deductible does apply to the Maximum Out of Pocket.

The plan year Maximum Out of Pocket applies to pharmacy and medical claims. Each individual family member must meet the individual Maximum Out of Pocket unless the family has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. Generic Dispense as Written policy does not apply to the Maximum Out of Pocket.

Retail Pharmacy Coverage (01–30 Day Supply)

Drug Type	In-Network Pharmacy
Generic	\$10
Preferred Brand	20% Coinsurance (Maximum \$100 per script)
Non-Preferred Brand	20% Coinsurance (Maximum \$200 per script)

Retail Pharmacy Coverage (31–90 Day Supply)

Drug Type	In-Network Pharmacy
Maintenance Generic	\$20
Maintenance Preferred Brand Medications	20% Coinsurance (Maximum \$200 per script)
Maintenance Non-Preferred Brand Medications	20% Coinsurance (Maximum \$400 per script)

Mail Order Extended Supply (01–90 Day Supply)

Drug Type	In-Network Pharmacy
Generic	\$20
Preferred Brand	20% Coinsurance (Maximum \$200 per script)
Non-Preferred Brand	20% Coinsurance (Maximum \$400 per script)

Specialty Medication

Specialty 30 Day Supply	20% Coinsurance (Maximum \$300 per script)
Specialty 90 Day Supply	20% Coinsurance (Maximum \$600 per script)

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through OptumRX specialty pharmacy by calling OptumRX at 1.855.427.4682. Some exceptions apply. These medications are limited to a 90-day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate copay/co-insurance as listed below. OptumRX Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

RxBenefits customer service: 1-800-334-8134 [optumrx.com](https://www.optumrx.com)

If there are any additional questions, please contact your Human Resource Department. Please note the effective date on this documentation is a reflection of the last update to this plan. This document is a current representation of the plan benefit at this time.