Jefferson City School District
HSA Plan-003/004

A UnitedHealthcare Company

Medical Benefits Covered Services	In-Network Providers	Non-Network Providers
Policy Year Deductible (Non-Embedded)		
Per Person	$1,500	$3,000
Family	$3,000	$6,000
Maximum Out-of-Pocket Expense		
Per Person	$3,000	$6,000
Family	$6,000	$12,000
Primary Care Office Visit	$25 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Specialist Office Visit	$35 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Physician Office Services	Deductible; plan pays 100%	Deductible; plan pays 70%
Urgent Care Visit	$35 copay after Deductible; plan pays 100%	$35 Copay after Deductible; plan pays 70%
Emergency Room	$100 copay after In Network Deductible; plan pays 100% (Copay waived if admitted)	
Ambulance	100% after In-Network deductible	
Durable Medical Equipment	Deductible; plan pays 100%	Deductible; plan pays 70%
Outpatient Diagnostic X-Ray and Lab	Deductible; plan pays 100%	Deductible; plan pays 70%
Outpatient Hospital Services	Deductible; plan pays 100%	Deductible; plan pays 70%
Inpatient Hospital Services	$100 copay after Deductible; plan pays 100%	$100 copay after Deductible; plan pays 70%
Physical Therapy	$35 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Speech/Hearing/Occupational Therapy	$35 copay after Deductible; plan pays 100%	Deductible; plan pays 70%
Teladoc-General Medicine	$15 Copay after Deductible	n/a
Teladoc-Dermatology	$15 Copay after Deductible	n/a
Teladoc-Behavioral Health	$15 Copay after Deductible	n/a
Preventive/Routine Exams	100%; (Deductible waived)	No benefit
Immunizations	100%; (Deductible waived)	No benefit
Preventive/Routine Diagnostic Lab & X-Rays	100%; (Deductible waived)	No benefit
Mammograms	100%; (Deductible waived)	No benefit
Preventive/Routine Pap Test	100%; (Deductible waived)	No benefit
Preventive/Routine PSA and Prostate	100%; (Deductible waived)	No benefit
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; (Deductible waived)	No benefit
Preventive/Routine Hearing Exam	100%; (Deductible waived)	No benefit
Women's Preventive Health Care	100%; (Deductible waived)	No benefit

Jefferson City School District
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Prescription Drug Benefits OptumRx Member Services 800-334-8134		
Policy Year Deductible (Medical & Pharmacy Combined)	**In Network**	
Per Person	**$1,500**	
Family	**$3,000**	
Maximum Out of Pocket Expense (Medical & Pharmacy Combined)		
Per Person	**$3,000**	
Family	**$6,000**	
Retail Pharmacy Option 30 Day Supply	**Participating Pharmacy**	**No Out of Network Benefit**
Tier 1	$10	
Tier 2	$30	
Tier 3	$50	
Retail 90 Pharmacy Option 31-90 Day Supply		
Tier 1	$20	
Tier 2	$60	
Tier 3	$100	
Mail Order Option -90 Day Supply		
Tier 1	$20	
Tier 2	$60	
Tier 3	$100	
Specialty Option- OptumRx Specialty		
Specialty Meds less than $1,000	$75	
Specialty Meds over $1,000	$125	

UMR Customer Service: 1-800-826-9781 www.umr.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.