

Jefferson City School District

Base Plan -001



A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Policy Year Deductible		
Per Person	\$1,000	\$2,000
Family	\$2,000	\$4,000
Maximum Out-of-Pocket Expense		
Per Policy Year		
Per Person	\$3,000	\$6,000
Family	\$6,000	\$12,000
Primary Care Physician Office Visits	100% after \$25 copay	60% after deductible
Specialist Office Visits	100% after \$35 copay	60% after deductible
Physician Office Services	80% after deductible	60% after deductible
Urgent Care Visit	\$35 copay; 80% after deductible	60% after deductible
Emergency Room (copay waived if admitted)	\$100 copay; 80% after deductible	
Ambulance	80% after in-network deductible	
Durable Medical Equipment	80% after deductible	60% after deductible
Outpatient Diagnostic X-ray and Lab	80% after deductible	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Inpatient Hospital Services	\$100 copay per admit ;80% after deductible	\$100 copay per admit ; 60% after deductible
Physical Therapy	\$35 copay; 100% deductible waived	60% after deductible
Speech, Hearing Occupational Therapy	\$35 copay; 100% deductible waived	60% after deductible
Preventive/Routine Exams	100%; deductible waived	No Benefit
Immunizations	100%; deductible waived	No Benefit
Preventive/Routine Diagnostic Lab and 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 Exams	100%; deductible waived	No Benefit
Women's Preventive Health Care	100%; deductible waived	No Benefit

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

Prescription Drug Benefits

Retail Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (30-day supply)

For Generic Drugs	\$10
For Preferred Brand Drugs	\$30
For Non-Preferred Brand Drug	\$50

Mail Order Option – Optum RX

Co-Pay Per Prescription (90-day supply)

For Generic Drugs	\$20
For Preferred Brand Drugs	\$60
For Non-Preferred Drugs	\$100

Specialty Option – Optum RX (Briova Rx)

Co-Pay Per Prescription (30-day supply)

Specialty Medications Less than \$1000	\$75
Specialty Medications Over \$1000	\$125

Optum RX Member Services: 1-800-334-8134