

**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	\$1,250	\$2,500
Family	\$2,500	\$5,000
Maximum Out-of-Pocket Expense		
Per Person	\$5,000	\$10,000
Family	\$10,000	\$20,000
Primary Care Office Visit	\$25 copay; plan pays 100% (Deductible waived)	Deductible; plan pays 60%
Specialist Office Visit	\$50 copay; plan pays 100% (Deductible waived)	Deductible; plan pays 60%
Outpatient Office Services	Deductible; plan pays 80%	Deductible; plan pays 60%
Urgent Care Visit	\$50 copay; plan pays 100% (Deductible waived)	Deductible; plan pays 60%
Emergency Room	In Network Deductible; plan pays 80%	
Ambulance	In-Network deductible; Plan pays 80%	
Durable Medical Equipment	Deductible; plan pays 80%	Deductible; plan pays 60%
Outpatient Diagnostic X-Ray and Lab	Deductible; plan pays 80%	Deductible; plan pays 60%
Outpatient Hospital Services	Deductible; plan pays 80%	Deductible; plan pays 60%
Inpatient Hospital Services	\$100 copay; Deductible; plan pays 80%	\$100 copay; Deductible; plan pays 60%
Physical Therapy	\$50 copay; plan pays 100% (Deductible waived)	Deductible; plan pays 60%
Speech/Hearing/Occupational Therapy	\$50 copay; plan pays 100% (Deductible waived)	Deductible; plan pays 60%
Teladoc-General Medicine	\$15 copay; plan pays 100% (Deductible waived)	n/a
Teladoc-Dermatology	\$15 copay; plan pays 100% (Deductible waived)	n/a
Teladoc-Behavioral Health	\$15 copay; plan pays 100% (Deductible waived)	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

Effective July 1, 2025

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Women’s Preventive Health Care	100%; (Deductible waived)	No benefit
Prescription Drug Benefits OptumRx Member Services 800-334-8134		
Retail Pharmacy Option 30 Day Supply	Participating Pharmacy	No Out of Network Benefit
Tier 1	\$10	
Tier 2	20% up to a \$100 per script maximum	
Tier 3	20% up to a \$200 per script maximum	
Retail 90 Pharmacy Option 31-90 Day Supply		
Tier 1	\$20	
Tier 2	20% up to a \$200 per script maximum	
Tier 3	20% up to a \$400 per script maximum	
Mail Order Option -90 Day Supply		
Tier 1	\$20	
Tier 2	20% up to a \$200 per script maximum	
Tier 3	20% up to a \$400 per script maximum	
Specialty Option- OptumRx Specialty		
Specialty Meds	20% up to a \$300 per script maximum	

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.

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