



HMO Benefit Overview

DE SOTO AREA SCHOOL DISTRICT
HMO1-1

Annual Deductible	\$4,000 / \$8,000 (Single/Family)
Coinsurance	0% Coinsurance
Annual Maximum Out of Pocket	\$4,000 / \$8,000 (Single/Family)
Deductible Type:	Embedded
Lifetime Maximum	Unlimited
Annual Maximum for Essential Benefits	Unlimited
Preventive Services	Unlimited
Dependent Age	26/26
Physician Services	
Office Visit	\$25 Copayment
Specialist Visit	\$50 Copayment
Chiropractor Visits	\$25 Copayment
Hearing Examination	\$25 Copayment
Podiatry Services	\$25 Copayment
Vision Services	\$25 Copayment
Weight Loss/Nutritional Counseling	\$25 Copayment
Hospital Services	
General Inpatient	Subject to Deductible, then 100% Coverage
Delivery & Newborn Charges	Subject to Deductible, then 100% Coverage
Outpatient Services	Subject to Deductible, then 100% Coverage
Emergency Services	
Emergency Room	\$250 Copayment
Urgent Care	\$100 Copayment
Ambulance	Subject to Deductible, then 100% Coverage
Pharmacy Benefits	
Tier 1/Tier 2/Tier 3	\$10/\$35/\$60/\$200 Spec Rx Copay
Value Tier	\$5 Rx Outcomes
Max Out-of-Pocket (Single/Family)	\$2,350 / \$4,700
Behavioral Health	
Inpatient	Subject to Deductible, then 100% Coverage
Transitional	Subject to Deductible, then 100% Coverage
Outpatient	
Psychiatrist or Psychologist	\$25 Copayment
Other Mental Health Professional	\$25 Copayment
Diagnostic Services	
Lab	Subject to Deductible, then 100% Coverage
X-Ray	Subject to Deductible, then 100% Coverage
MRI/MRA Scan	Subject to Deductible, then 100% Coverage
PET Scan	Subject to Deductible, then 100% Coverage
CAT Scan	Subject to Deductible, then 100% Coverage
Other Services	
Anesthesia for Dental	Subject to Deductible and Coinsurance
Autism Spectrum Disorder	See Specific Benefit Category for Applicable Coverage
Durable Medical Equipment	20% Coinsurance
Home Health Care Services	Subject to Deductible, then 100% Coverage
Hospice Services	Subject to Deductible, then 100% Coverage
Kidney Disease Treatment	See Specific Benefit Category for Applicable Coverage
Oral Surgery	0% Coinsurance
Skilled Nursing Care Facility	Subject to Deductible, then 100% Coverage
Therapy Services	Subject to Deductible, then 100% Coverage
TMJ Benefits	\$25 Copayment

This Benefits Summary is intended to highlight the benefits provided in policy listed above. Please see your policy, including the Certificate of Coverage and Schedule of Benefits (SOB), for limitations and exclusions.