MERCER

KINGSLEY-PIERSON COMMUNITY SCHOOL DISTRICT

EDUCATORS GROUP PLAN OPTIONS

EFFECTIVE JULY 1, 2020 - JUNE 30, 2021

Medical		Copay Select 1000		Copay Select 1500		Copay Select 3000		HDHP 3000 NE	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network		Alliance Select		Alliance Select		Alliance Select		Alliance Select	
Deductible	Employee	$1,000		$1,500		$3,000		$3,000	
(Annual)	Family	$2,000		$3,000		$6,000		$6,000 +	
Out-of-Pocket Maximum	Employee	$2,000		$3,000		$6,000		$3,000	
(Annual)	Family	$4,000		$6,000		$12,000		$6,000 +	
Coinsurance		20%	30%	20%	30%	25%	35%	NA	NA
Office Visits - Primary Care		$10 Copay	30% coinsurance after deductible	$15 Copay	30% coinsurance after deductible	$25 Copay	35% coinsurance after deductible	Deductible Applies	
Office Visits - Specialty Care		$20 Copay	30% coinsurance after deductible	$30 Copay	30% coinsurance after deductible	$50 Copay	35% coinsurance after deductible	Deductible Applies	
Telehealth - Doctor on Demand		$10 Copay	NA	$15 Copay	NA	$25 Copay	NA	$49 per virtual medical visit	NA
Preventive Care: *Adult Health Exam; Well Child to age 7; Well-Woman Services; Immunizations and Routine Vision Exam*		0% In-Network	30% coinsurance after deductible	0% In-Network	30% coinsurance after deductible	0% In-Network	35% coinsurance after deductible	0% In-Network	Deductible Applies
Hospitalization - Inpatient or Outpatient		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Emergency Room		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Mental Health / Chemical Dependency - Inpatient or Outpatient		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Ambulance		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Durable Medical Equipment		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Outpatient Therapy (Speech, occupational, physical)		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Diagnostic X-Rays and Labs		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Infertility Benefits*		$25,000 lifetime maximum for transfer procedures		$25,000 lifetime maximum for transfer procedures		$25,000 lifetime maximum for transfer procedures		Up to Diagnosis only	
Orthotic Devices		20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Not Covered	

Pharmacy		Copay Select 1000	Copay Select 1500	Copay Select 3000	HDHP 3000 NE
Network		In-Network Value Plus Rx	In-Network Value Plus Rx	In-Network Value Plus Rx	In-Network Value Plus Rx
Rx Deductible *(Waived for Tier 1)*	Single	$50	$50	$50	Medical Deductible applies
Retail Pharmacy *(30-day supply)*	Family	$100	$100	$100	
	Tier 1	$10	$10	$8	
	Tier 2	$20	$25	$35	
	Tier 3	$30	$40	> $50 or 50%, whichever is greater	
Specialty Preferred		$85	$85	$85	
Specialty Non-Preferred		$85	$85	$85	
RX Out-of-Pocket Maximum	Single	$1,500	$1,500	$1,500	
	Family	$3,000	$3,000	$3,000	
Mail Order *(90-day supply)*	Tier 1	$20	$20	$16	
	Tier 2	$40	$50	$70	
Rx Deductible applies; is waived for Tier 1	Tier 3	$60	$80	> $100 or 50%, whichever is greater	

Premium Rates	Copay Select 1000	Copay Select 1500	Copay Select 3000	HDHP 3000 NE
Single	**$731.86**	**$698.50**	**$615.60**	**$590.67**
Family	**$1,778.63**	**$1,695.24**	**$1,487.99**	**$1,425.67**
Single - Annual	$8,782.32	$8,382.00	$7,387.20	$7,088.04
Family - Annual	$21,343.56	$20,342.88	$17,855.88	$17,108.04

NOTES:

Doctor on Demand: Doctor On Demand is a virtual visit platform that immediately connects you to a board-certified physician by live video on your smartphone, tablet or computer. - Member cost to use Doctor on Demand is the same coinsurance % or Copay $ as that for a Primary Office Visit. **HDHP:** Member cost to use Doctor On Demand is $49; or $80 to $189 (depending on length) for Psychologist. Coverage for psychiatry services has been added as well as Office Medication Management services. Deductible is waived.

* Eligible infertility charges are covered as any other service and coinsurance will apply to annual out-of-pocket maximum.
Removal of impacted teeth: Surgical removal of impacted teeth is covered as an inpatient or outpatient, but only with a concurrent medical condition
Treatment of temporomandibular (TMJ) joint disorder is not covered.

Pharmacy: If you use a nonparticipating pharmacy, you must pay the amount charged at the time of purchase, and the amount Wellmark reimburses you may be less than what you paid. You are responsible for this difference.

Rx Product Selection Penalty Rule - Copay Select RX: When a brand drug is obtained and there is an equivalent generic drug available, the member is responsible for paying their payment obligation for the equivalent generic (i.e. lowest payment application) and any remaining cost difference up to the maximum allowed fee for the brand name drug.

HDHP Notes: No 4th quarter deductible carry-over.

* **Non-Embedded Deductible:** This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. Family deductible is reached from amounts accumulated on behalf of any covered family member or combination of covered family members. You must satisfy the entire family deductible before Wellmark will make benefit payments.

RX Product Selection Penalty Rule - HDHP: When a brand drug is obtained and there is an equivalent generic drug available, the member is responsible for paying their payment obligation for the equivalent generic (i.e. lowest payment application) and any remaining cost difference up to the maximum allowed fee for the brand name drug except when the provider writes "Dispense as Written" (in this case, the member pays only the appropriate payment application).

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply.