



**Union Community Schools
EDUCATORS GROUP PLAN OPTIONS
EFFECTIVE JULY 1, 2020 - JUNE 30, 2021**

Medical Network		Classic 500		Select 1500		HDHP 2500 NE	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
		Alliance Select		Alliance Select		Alliance Select	
Deductible (Annual)	Employee Family	\$500 \$1,000		\$1,500 \$3,000		\$2,500 \$5,000 ⁺	
Out-of-Pocket Maximum (Annual)	Employee Family	\$1,000 \$2,000		\$3,000 \$6,000		\$2,500 \$5,000 ⁺	
Coinsurance		10%	20%	25%	35%	NA	NA
Office Visits - Primary Care		10% coinsurance; Deductible waived	20% coinsurance after deductible	25% coinsurance; Deductible waived	35% coinsurance after deductible	Deductible Applies	
Office Visits - Specialty Care		10% coinsurance; Deductible waived	20% coinsurance after deductible	25% coinsurance; Deductible waived	35% coinsurance after deductible	Deductible Applies	
Telehealth - Doctor on Demand		10% coinsurance; Deductible waived	NA	25% coinsurance; Deductible waived	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	20% coinsurance after deductible	0% In-Network	35% coinsurance after deductible	0% In-Network	Deductible Applies
Hospitalization - Inpatient or Outpatient		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Emergency Room		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Mental Health / Chemical Dependency - Inpatient or Outpatient		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Ambulance		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Durable Medical Equipment		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Outpatient Therapy (Speech, occupational, physical)		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Deductible Applies	
Diagnostic X-Rays and Labs		10% coinsurance after deductible	20% 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		Up to Diagnosis only	
Orthotic Devices		10% coinsurance after deductible	20% coinsurance after deductible	25% coinsurance after deductible	35% coinsurance after deductible	Not Covered	

Pharmacy		Classic 500	Select 1500	HDHP 2500 NE
Wellmark Drug List		In-Network Blue Value Plus Rx	In-Network Blue Value Plus Rx	In-Network Blue Value Plus Rx
Rx Deductible (Waived for Tier 1)	Single		\$50	Medical Deductible applies
Retail Pharmacy (30-day supply)	Family		\$100	
	Tier 1		\$10	
	Tier 2		\$25	
	Tier 3		\$40	
Specialty Preferred		Deductible then 20% coinsurance. Medical and Rx Deductible and Out-of-Pocket Maximum are combined.	\$85	
Specialty Non-Preferred			\$85	
RX Out-of-Pocket Maximum	Single		\$1,500	
	Family		\$3,000	
Mail Order (90-day supply)	Tier 1		\$20	
	Tier 2		\$50	
Rx Deductible applies; is waived for Tier 1	Tier 3		\$80	
Premium Rates		Classic 500	Select 1500	HDHP 2500 NE
Monthly				
Monthly Premium - Single				
Monthly Premium - Family				

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 - 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).

MV Notes: Embedded Deductible; No 4th quarter deductible carry-over; Vision exam not covered.

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.