Security Administrative Services

Wausau School District
MED1
Effective Date: 1/1/2019
Benefit Year: January-December
Non-grandfathered Plan

Wausau School District
Network Choice Plan

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in your Summary Plan Description. Please note all Out-of-Network Provider charges are subject to usual, customary and reasonable fees. It is strongly recommended that you read the entire summary plan description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

Your Responsibilities	In network	Out of network
Deductible	$300 individual $600 family	$300 individual $600 family
Coinsurance	0%	20% of the next $3,000 individual $6,000 family
Annual out of pocket Deductible, coinsurance, and copays. Includes prescription copays. In-network amounts accumulate to the out-of-network out-of-pocket maximum. Out-of-network amounts accumulate to the in-network, out-of-pocket maximum.	$7,350 individual $14,700 family	$7,350 individual $14,700 family
Deductible Carryover: If a covered person incurs eligible charges during the period beginning October 1 through December 31 which are applied to the deductible for that calendar year, those charges are also applied toward satisfaction of the deductible for the subsequent calendar year.		

Your Benefits	In network	Out of network
Ambulance services	Subject to deductible	Subject to in-network deductible
Anesthesia services	Subject to deductible	Subject to deductible and coinsurance
Astia Health	In Clinic Services – 100% Mobile Services – 100%. $10 travel fee applies for any mobile services requested. 100% coverage is limited to certain services	
Chiropractic Services		
• **Office visit or manipulations and therapies**	$15 copayment per visit	Subject to deductible and coinsurance
• **X-rays**	Subject to deductible	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
Durable medical equipment and medical supplies	Subject to deductible	Subject to deductible and coinsurance
Hearing examinations	Subject to deductible	Subject to deductible and coinsurance
Home health care Limited to 40 visits per calendar year	Subject to deductible	Subject to deductible and coinsurance
Hospice care	Subject to deductible	Subject to deductible and coinsurance
Hospital emergency room services		
• **Emergency room facility** Copayment waived if admitted to hospital as inpatient within 24 hours)	$100 copayment per visit	$100 copayment per visit
• **Other emergency room services**	Subject to deductible	Subject to in-network deductible
Hospital inpatient services Pre-certification required Including semi-private or special care room, operating room, ancillary services and supplies	Subject to deductible	Subject to deductible and coinsurance
Hospital outpatient and surgical center services Not including emergency room	Subject to deductible	Subject to deductible and coinsurance
Maternity services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Physician services**	Subject to deductible	Subject to deductible and coinsurance
Mental health and substance abuse services		
• **Bereavement counseling** Lifetime limit of 6 months	Subject to deductible	Subject to deductible and coinsurance
• **Inpatient care** Pre-certification required	Subject to deductible	Subject to deductible (coinsurance waived)
• **Outpatient care**	Covered at 100% (deductible waived)	Subject to 10% coinsurance (deductible waived)
• **Transitional care**	Covered at 100% (deductible waived)	Subject to 10% coinsurance (deductible waived)

Your Benefits	In network	Out of network
Office visit Includes urgent care	$15 copayment per visit	Subject to deductible and coinsurance
Outpatient laboratory Services	Subject to deductible	Subject to deductible and coinsurance
Outpatient radiology Services	Subject to deductible	Subject to deductible and coinsurance
Outpatient therapy services Prior authorization required		
• **Occupational therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Physical therapy**	Subject to deductible	Subject to deductible and coinsurance
• **Speech therapy**	Subject to deductible	Subject to deductible and coinsurance
Physician services		
• **Hospital services**	Subject to deductible	Subject to deductible and coinsurance
• **Other services in an office**	Subject to deductible	Subject to deductible and coinsurance
Preventive benefit – Up to Age 19 ***Services MUST be coded as preventive to be paid at 100%. Deductible and coinsurance will apply to services not coded as preventive.		
• **Comprehensive physical examination** ~ Well-baby care ~ Well-child care ~ Adolescent well-care	Covered at 100% (deductible waived)	Not covered
• **Comprehensive preventive vision examination** Includes refraction	Covered at 100% (deductible waived)	Not covered
• **Immunizations and vaccinations**	Covered at 100% (deductible waived)	Subject to deductible and coinsurance

Your Benefits	In network	Out of network
• **Preventive lab services** Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.	Covered at 100% (deductible waived)	Not covered
Preventive benefit – Age 19 and over ***Services MUST be coded as preventive to be paid at 100%. Deductible and coinsurance will apply to services not coded as preventive.		
• **Immunizations and vaccinations**	Covered at 100% (deductible waived)	Not covered
• **Gynecological examination** Breast exam and pelvic exam	Covered at 100% (deductible waived)	Not covered
• **Pap smear to screen for cervical cancer**	Covered at 100% (deductible waived)	Not covered
• **Mammogram to screen for breast cancer** Age 40 and older	Covered at 100% (deductible waived)	Covered at 100% (deductible waived)
• **Comprehensive physical examination**	Covered at 100% (deductible waived)	Not covered
• **Comprehensive preventive vision examination** Includes refraction	Covered at 100% (deductible waived)	Not covered
• **Digital prostate examination**	Covered at 100% (deductible waived)	Not covered
• **Colonoscopy, sigmoidoscopy screening for colorectal cancer**	Covered at 100% (deductible waived)	Not covered
• **Preventive labs services** Including, but are not limited to: basic metabolic panel, comprehensive metabolic panel, general health panel, lipoprotein, lipid panel, glucose (blood sugar), complete blood count (CBC), hemoglobin, thyroid stimulating hormone (TSH), prostate specific antigen (PSA), and urinalysis.	Covered at 100% (deductible waived)	Not covered

Your Benefits	In network	Out of network
Prosthetic devices	Subject to deductible	Subject to deductible and coinsurance
Skilled nursing and/or rehabilitation facility Limited to 30 days per disability	Subject to deductible	Subject to deductible (coinsurance waived)
Surgical services	Subject to deductible	Subject to deductible and coinsurance
Temporomandibular joint disorders (TMJ) treatment	Subject to deductible	Subject to deductible and coinsurance
Transplant services		
• **Transplant procedure and facility charges** Prior authorization required	Subject to deductible	Subject to deductible and coinsurance
• **Organ procurement and acquisition** Prior authorization required	Subject to deductible	Subject to deductible and coinsurance
• **Donor expenses** Prior authorization required Max of $10,000 per transplant	Subject to deductible	Subject to deductible and coinsurance
Vision examinations	Subject to deductible	Subject to deductible and coinsurance
All other covered	Subject to deductible	Subject to deductible and coinsurance

Precertification Required **Contact Hines and Associates at 800.483.5984**

• All Inpatient hospitalizations
• Skilled Nursing Facility and Residential Stays
• Transplants
• Physical, Occupational, and Speech therapy
• Second Surgical Opinions
• Outpatient surgery including:
  o Abdominoplasty
  o Carpel Tunnel Release
  o Cosmetic/Reconstructive Surgery
  o Hip Replacement
  o Infuse Bone Graft
  o Knee Replacement
  o Panniculectomy
  o Port Wine Stain – Abnormal Vascular Lesion Treatment
  o Reduction Mammoplasty
  o Rhinoplasty
  o Septoplasty
  o Spinal Cord Stimulator

Pharmacy administered by RxBenefits 1-800-334-8134	
The difference in cost between a Generic product and Brand product will be applied in addition to the copayment unless a Medical Professional has specified a Brand Product or has indicated that the Brand is necessary.	
Prescription Drug Card Program — Tier I	$5.00 copayment limited to a 90-day supply
Prescription Drug Card Program — Tier II	$15.00 copayment limited to a 90-day supply
Prescription Drug Card Program — Tier III	$30.00 copayment limited to a 90-day supply
Diabetic Supplies	$0 copayment limited to a 90-day supply
Non-Participating Pharmacy	Will be reimbursed at the lowest contracted amount less any copayment amounts to the employee only.