Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons

Clarinda Community School District

BENEFIT	$750 / $1,500 ALLIANCE SELECT HEALTH PLAN		$1,500 / $3,000 ALLIANCE SELECT HEALTH PLAN	
	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible				
Single	$750 / Single		$1,500 / Single	
Family	$1,500 / Family		$3,000 / Family	
Out-of-Pocket Maximums				
Single	$1,500 / Single		$3,000 / Single	
Family	$3,000 / Family		$6,000 / Family	
Coinsurance	20%	30%	20%	30%
Lifetime Benefits Maximum	Unlimited		Unlimited	
Lifetime Infertility Maximum	$25,000		$25,000	
Office Visit Services	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible
Specific Preventive Care Includes: One routine physical per benefit period, a separate gynecological exam is also covered, related services, well-child care to age 7 and mammography.	Routine Health Care (age 7 or older)		Routine Health Care (age 7 or older)	
	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
	Well-Child Care (under age 7)		Well-Child Care (under age 7)	
	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
	Childhood Immunization (under age 7)		Childhood Immunization (under age 7)	
	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*	Paid at 100% *deductible & coinsurance waived*
Inpatient Hospital Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Emergency Services				
Physician's Office	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible
Emergency Room	$200 Copay Copay Waived if Admitted	$200 Copay Copay Waived if Admitted	$200 Copay Copay Waived if Admitted	$200 Copay Copay Waived if Admitted
Chiropractic Care	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible
Maternity Care Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Infertility Treatment				
Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Office Visit	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible
Mental Health/Chemical Dependency				
Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Office Services	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible	$10 Copay *deductible & coinsurance waived*	30% coinsurance after deductible
Prescription Drug				
Retail				
Generic (30 Day Supply)	$10 Copay Generic		$10 Copay Generic	
Formulary (Brand PPO) (30 Day Supply)	$20 Copay Brand Name		$20 Copay Brand Name	
Non-Formulary (30 Day Supply)	$50 Ded Single/$100 Ded Family (Waived for Generic)		$50 Ded Single/$100 Ded Family (Waived for Generic)	
Mail Order				
Generic (90 Day Supply)	$20 Copay Generic		$20 Copay Generic	
Formulary (Brand PPO) (90 Day Supply)	$40 Copay Brand Name		$40 Copay Brand Name	
Non-Formulary (90 Day Supply)				
Rates 7/1/23				
Single	$825.00		$800.00	
Family	$2,100.00		$2,025.00	

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.