Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons

Clarinda Community Schools Rates Effective: July 1, 2017



more day to every gets (Ob alone day		\$500 / \$1,000 ALLIANCE SELECT HEALTH PLAN \$ 766.02 Single / \$1,915.03 Family		
mention countries	SELECT PROVIDERS	NON-SELECT PROVIDERS		
Benefit Period Deductible Sinale	(IN - NETWORK) (OUT - OF - NETWORK) \$500 / Single			
Family	\$1,000 / Family			
Out-of-Pocket Maximums Single Family	\$1,000 / Single \$2,000 / Family			
Coinsurance	10% 20%			
Lifetime Benefits Maximum				
	Unlimited			
ifetime Infertility Maximum	\$25,000			
Office Visit Services	\$10 Copay deductible & coinsurance waived	20% coinsurance after deductible		
Specific Preventive Care Includes: One routine physical per benefit period a separate gynecological exam well-child care to age 7	NO Copay deductible & coinsurance waived	NO Copay deductible & coinsurance waived		
Must be coded "Preventative"				
Mammography	\$10 Copay	20% coinsurance		
one per benefit period	deductible & coinsurance waived	after deductible		
npatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible		
Outpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible		
Outpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible		
Emergency Services** Physician's Office Emergency Room	\$10 Copay deductible & coinsurance waived \$100 Copay	20% coinsurance after deductible \$100 Copay		
	Copay waived if admitted \$10 Copay	Copay waived if admitted 20% coinsurance		
Chiropractic Care	deductible & coinsurance waived after deductible			
Maternity Care Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible		
Infertility Treatment Inpatient / Outpatient Office Visit	10% coinsurance after deductible \$10 Copay	20% coinsurance after deductible 20% coinsurance		
Mental Health/Chemical	deductible & coinsurance waived	after deductible		
viental Health/Chemical Dependency				
Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible		
Office Services	\$10 Copay deductible & coinsurance waived	20% coinsurance after deductible		
	** Processed at in-network level if true emergency.			
	Rx Information for \$500 deductible Annual Deductible Generic Copayment Brand Name Copayment	\$50 single, \$100 family - waived for generics \$10 \$20		
his is a general description of coverage. It is not a statement of contract. Act overage is subject to terms and conditions secified in the Benefits Certificate viil receive after you enroll and the enrollment regulations in force when the ertificate becomes effective. Certain exclusions and limitations apply.		Quantities: Mail order maintenance prescriptions: 90-day supply for 2 copayments Maintenance prescriptions purchased at Advance Rx pharmacy: 90-day supply for 1 copayments. All other prescriptions: 30-day supply for 1 copayment.		

Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons Clarinda Community Schools Rates Effective: July 1, 2017





areny day, in every work 401 come share		or ori roy light yill but hi	#4 FOR / #2 OOD #11 74N	CE CELECT HEALTH BLAN
	\$750 / \$1,500 ALLIANCE SELECT HEALTH PLAN \$745.86 Single / \$1,864.65 Family		\$1,500 / \$3,000 ALLIANCE SELECT HEALTH PLAN \$671.21 Single / \$1,677.97 Family	
	SELECT PROVIDERS	NON-SELECT PROVIDERS	SELECT PROVIDERS	NON-SELECT PROVIDERS
	(IN - NETWORK)	(OUT - OF - NETWORK)	(IN - NETWORK)	(OUT - OF - NETWORK)
Benefit Period Deductible				Service Servic
Single		/ Single	\$1,500 / Single \$3,000 / Family	
Family	\$1,500) / Family		
Out-of-Pocket Maximums				
Single		0 / Single	\$3,000 / Single \$6,000 / Family	
Family	\$3,000) / Family		
Coinsurance	10%	20%	10%	20%
ifetime Benefits Maximum	Unlimited		Unlimited	
ifetime Infertility Maximum	\$25,000		\$25,000	
Office Visit Services	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
	deductible & coinsurance waived	after deductible	deductible & coinsurance waived	after deductible
Specific Preventive Care	deductible of collisarance warved	and deddelible	dedicate a contentation trained	unter deddetate
ncludes:				
One routine physical per benefit period	No Copay	NO Copay	No Copay	NO Copay
separate gynecological exam	deductible & coinsurance waived	deductible & coinsurance waived	deductible & coinsurance waived	deductible & coinsurance waived
ell-child care to age 7				
lust be coded "Preventative"				
Mammography	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
ne per benefit period	deductible & coinsurance waived	after deductible	deductible & coinsurance waived	after deductible
Inpatient Hospital Services	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
	after deductible	after deductible	after deductible	after deductible
Outpatient Physician Services	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
	after deductible	after deductible	after deductible	after deductible
Outpatient Hospital Services	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
	after deductible	after deductible	after deductible	after deductible
	alter deductible	aitel deductible	alter deductible	aitel deductible
mergency Services**	4.5	000/	000 0	200/!
Physician's Office	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
Francisco Poom	deductible & coinsurance waived	after deductible	deductible & coinsurance waived \$100 Copay	after deductible \$100 Copay
Emergency Room	\$100 Copay	\$100 Copay Copay waived if admitted	Copay waived if admitted	Copay waived if admitted
	Copay waived if admitted			
Chiropractic Care	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
	deductible & coinsurance waived	after deductible	deductible & coinsurance waived	after deductible
Maternity Care	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
Inpatient / Outpatient	after deductible	after deductible	after deductible	after deductible
nfertility Treatment				
Inpatient / Outpatient	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
	after deductible	after deductible	after deductible	after deductible
Office Visit	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
Silios Viole	deductible & coinsurance waived	after deductible	deductible & coinsurance waived	after deductible
lental Health/Chemical				
ependency	1			
Inpatient / Outpatient	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
	after deductible	after deductible	after deductible	after deductible
Office Services	\$15 Copay	20% coinsurance	\$20 Copay	20% coinsurance
	deductible & coinsurance waived	after deductible	deductible & coinsurance waived	after deductible
	** Processed at in-network level if true en	nergency.		
	Rx Information for \$750 deductible		Rx Information for \$1,500 deductible	
	Annual Deductible	\$50 single, \$100 family - waived for generics		\$50 single, \$100 family - waived for gene
	Generic Copayment	\$10	Generic Copayment Brand Name Copayment	\$10 \$20
	Brand Name Copayment	\$20	ргани мате Сораутент	\$20
	When you have a prescription filled at an Advance Rx	Drug Quantities: Mail Order	Maintenance prescriptions purchased at Advance Rx	All Other prescriptions: 30-day supply for one
his is a general description of coverage. It is not a statement of contract. Actual	pharmacy, you are responsible for the lower fixed-dollar	maintenance prescriptions: 90-day supply for two	pharmacy: 90-day supply for three copayments.	copayment.
overage is subject to terms and conditions secified in the Benefits Certificate you	amount (copayment) for a generic drug or the higher	copayments.		
ill receive after you enroll and the enrollment regulations in force when the	copayment for a brand name. All drugs must be self- administered according to instructions given by the			
ertificate becomes effective. Certain exclusions and limitations apply.	administrate according to instructions given by the			