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

	$500 / $1,000 ALLIANCE SELECT HEALTH PLAN $ 766.02 Single / $1,915.03 Family	
	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single Family	**$500 / Single** **$1,000 / Family**	
Out-of-Pocket Maximums Single Family	**$1,000 / Single** **$2,000 / Family**	
Coinsurance	10%	20%
Lifetime Benefits Maximum	Unlimited	
Lifetime 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 Must be coded "Preventative"	**NO Copay** ***deductible & coinsurance waived***	**NO Copay** ***deductible & coinsurance waived***
Mammography one per benefit period	**$10 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Inpatient 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	**$10 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Emergency Room	**$100 Copay** Copay waived if admitted	**$100 Copay** Copay waived if admitted
Chiropractic Care	**$10 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Maternity Care Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Infertility Treatment Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office Visit	**$10 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Mental 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	$50 single, $100 family - waived for generics
	Generic Copayment	$10
	Brand Name Copayment	$20

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions secified 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.	When you have a prescription filled at an AdvanceRx pharmacy, you are responsible for the lower fixed-dollar amount (copayment) for a generic drug or the higher copayment for a brandname. All drugs must be self-administered according to instructions given by the practitioner and the pharmacist.	Quantities: Mail order maintenance prescriptions: 90-day supply for 2 copayments. Maintenance prescriptions purchased at Advance Rx pharmacy: 90-day supply for 3 copayments. All other prescriptions: 30-day supply for 1 copayment.

Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons
Clarinda Community Schools
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	$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 (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single Family	**$750 / Single** **$1,500 / Family**		**$1,500 / Single** **$3,000 / Family**	
Out-of-Pocket Maximums Single Family	**$1,500 / Single** **$3,000 / Family**		**$3,000 / Single** **$6,000 / Family**	
Coinsurance	10%	20%	10%	20%
Lifetime Benefits Maximum	Unlimited		Unlimited	
Lifetime Infertility Maximum	$25,000		$25,000	
Office Visit Services	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 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 Must be coded "Preventative"	**No Copay** ***deductible & coinsurance waived***	**NO Copay** ***deductible & coinsurance waived***	**No Copay** ***deductible & coinsurance waived***	**NO Copay** ***deductible & coinsurance waived***
Mammography one per benefit period	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Inpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Services** Physician's Office	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Emergency Room	**$100 Copay** Copay waived if admitted	**$100 Copay** Copay waived if admitted	**$100 Copay** Copay waived if admitted	**$100 Copay** Copay waived if admitted
Chiropractic Care	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Maternity Care Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Infertility Treatment Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Office Visit	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
Mental Health/Chemical Dependency Inpatient / Outpatient	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
Office Services	**$15 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible	**$20 Copay** ***deductible & coinsurance waived***	20% coinsurance after deductible
	***** Processed at in-network level if true emergency.***			
	Rx Information for $750 deductible		Rx Information for $1,500 deductible	
	Annual Deductible	$50 single, $100 family - waived for generics	**Annual Deductible**	$50 single, $100 family - waived for generics
	Generic Copayment	$10	**Generic Copayment**	$10
	Brand Name Copayment	$20	**Brand Name Copayment**	$20

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Drug Quantities: Mail Order maintenance prescriptions: 90-day supply for two copayments.

Maintenance prescriptions purchased at Advance Rx pharmacy: 90-day supply for three copayments.

All Other prescriptions: 30-day supply for one copayment.