MERCER

ADEL-DESOTO-MINBURN COMMUNITY SCHOOLS

Educators Group Plan Options

Rates Effective 7/1/2017 - 6/30/2018

NEW OPTIONS

	Wellmark Health Plan of Iowa **Blue Advantage**	**Wellmark Blue Cross Blue Shield Copay 750**	***Wellmark Blue Cross Blue Shield*** **Copay 1250**
Provider Network	Wellmark Health Plan of Iowa (WHPI) - HMO	Alliance Select - PPO	Alliance Select - PPO
Calendar Year Deductible	None	$750 Single/$1,500 Family Annual Deductible	$1,250 Single/$2,500 Family Annual Deductible
Coinsurance	10%	20% in-network; 30% out-of-network	20% in-network; 30% out-of-network
Annual Out of Pocket Maximum (OPM)	$750 Single / $1,500 Family	$1,500 Single/$3,000 Family Annual OPM	$2,500 Single/$5,000 Family Annual OPM
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physician (Office) Services* **			
Office Visits	$10 Copayment	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance
Chiropractic Care	$10 Copayment	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance
Doctor On Demand (Virtual Visits) **- Doctor and Psychologist**	$10 Copayment	$10 Copay	$10 Copay
Allergy Testing & Injections *(Serum subject to deductible)*	$10 Copayment	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance	In-Network: $10 Copay Out-of-Network: Deductible, then 30% coinsurance
Preventive Care			
Routine Office Services *Annual Routine Physical*** *Annual Well-Woman Exam* *Annual Mammogram* *Annual Vision Exam* *Well-Child Care* *Immunizations / flu shots*	Covered services paid at 100% Covered according to the Plan's preventive guidelines or the mandated schedule Covered according to preventive care guidelines	In-Network: Covered services paid at 100% Out-of-Network: Deductible, then 30% coinsurance *Deductible waived for out-of-network providers*	In-Network: Covered services paid at 100% Out-of-Network: Deductible, then 30% coinsurance Deductible waived for out-of-network providers
Reminder Programs	Included for pap smears, mammograms, and immunizations	Included for pap smears, mammograms, and immunizations	Included for pap smears, mammograms, and immunizations
Blue Rx Complete Prescription Drug Coverage			
Rx Deductible	NA	NA	None
Rx Copayments	$5-Generic/ $10-Brand / $85 Specialty	$10-Tier 1 / $25-Tier 2 / $40-Tier 3 & 4 / $85 Specialty	$10-Tier 1 / $20-Tier 2 / $30-Tier 3 / $85 Specialty
Rx Out of Pocket Maximum	$1,500 Single / $3,000 Family Rx OPM	$1,500 Single / $3,000 Family Rx OPM	$250 Single/$500 Family OPM
Facility Services			
Inpatient Hospital Charges	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Inpatient Physician Charges	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Facility Services			
Outpatient Hospital Charges	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Outpatient Physician Charges	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Emergency Room Hospital Charges* **	$50 Copayment	In-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 20% coinsurance
Emergency Services **Non-Emergency Services**	There are no out-of-network benefits except for emergency care.	Out-of-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	Out-of-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance

	Wellmark Health Plan of Iowa **Blue Advantage**	**Wellmark Blue Cross Blue Shield Copay 750**	***Wellmark Blue Cross Blue Shield*** **Copay 1250**
Diagnostic X-ray and Lab	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Maternity Care	Physician Services covered in full	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Mental Health / Chemical Dependency			
Inpatient	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Outpatient	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Office Visits	$10 Copayment *(care must be pre-certified by triage process)*	In-Network: $10 copay Out-of-Network: Deductible, then 30% coinsurance	In-Network: $10 copay Out-of-Network: Deductible, then 30% coinsurance
Miscellaneous Services			
Infertility Treatment****	$15,000 lifetime maximum for transfer procedures	$25,000 Lifetime maximum for transfer procedures	$25,000 Lifetime maximum for transfer procedures
Durable Medical Equipment	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Ambulance	10% Coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Impacted Teeth	Inpatient or outpatient covered only with a concurrent medical condition.	Outpatient Surgery for impacted teeth covered. Inpatient covered with concurrent medical condition.	Outpatient Surgery for impacted teeth covered. Inpatient covered with concurrent medical condition.
Orthotic Devices	Not Covered	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance; Out-of-Network: Deductible, then 30% coinsurance
Diabetic Education	Includes up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 mo period and up to 2 hours in each subsequent year.	Includes up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 mo period and up to 2 hours in each subsequent year.	Includes up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 mo period and up to 2 hours in each subsequent year.
BlueCard Services-Care Outside of Iowa	Coverage for emergency care only	Provides enhanced benefits for services provided by participating providers outside of Iowa.	Provides enhanced benefits for services provided by participating providers outside of Iowa.
Monthly Rates			
Single	$505.81	$514.05	$500.26
2-Person	$972.39	$988.78	$961.35
Family	$1,460.40	$1,485.31	$1,443.62

Blue Advantage benefits are only available for services obtained through the Wellmark Health Plan of Iowa (WHPI) network. There are no out-of-network benefits except for emergency care.

- Physician services must be coordinated by your Wellmark Health Plan of Iowa Primary Care Physician (PCP). Facility services are only covered if contracted with Wellmark Health Plan of Iowa.

- To offer Blue Advantage as an option, 10% of eligible employees must enroll in the plan.

-**Blue Advantage RX Product Selection Penalty Rule:** 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).

- Copayments for office and emergency room services apply to the annual out-of-pocket maximum.

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 as that for an Office Visit. - Available for use outside of WHIPI network.

*Deductible will be waived for facility and practitioner billed preventive procedures performed at an Alliance Select Facility (inpatient or outpatient).

**Health maintenance exams (physicals) for school, sports, insurance, employment, and travel will not be covered. Physicals for routine preventive care continue to be covered.

****Eligible infertility charges are covered as any other service and coinsurance will apply to annual out-of-pocket maximum.

Plan allows for one routine physical examination per benefit period. A separate well-woman exam is also covered once per benefit period.

- Deductible will be waived for facility and practitioner billed preventive procedures performed at an Alliance Select Facility (inpatient or outpatient).

Copay Rx - Product Selection Penalty Rule: 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.

This is a brief description only and does not replace the contract.

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ADEL-DESOTO-MINBURN COMMUNITY SCHOOLS

Educators Group Plan Options

Rates Effective 7/1/2017 - 6/30/2018

	Wellmark Blue Cross Blue Shield Classic 100
Provider Network	Alliance Select - PPO
Calendar Year Deductible	$100 Single/$200 Family Annual Deductible
Coinsurance	10% in-network; 20% out-of-network
Annual Out of Pocket Maximum (OPM)	$500 Single OR Family Annual OPM
Lifetime Maximum	Unlimited
Physician (Office) Services* **	
Office Visits	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance
Chiropractic Care	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance
Doctor On Demand (Virtual Visits) **- Doctor and Psychologist**	Deductible waived; 10% coinsurance
Allergy Testing & Injections *(Serum subject to deductible)*	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance
Preventive Care	
Routine Office Services *Annual Routine Physical*** *Annual Well-Woman Exam* *Annual Mammogram* *Annual Vision Exam* *Well-Child Care* *Immunizations / flu shots*	In-Network: Covered services paid at 100% Out-of-Network: Deductible, then 20% coinsurance *Deductible waived for out-of-network providers*
Reminder Programs	Included for pap smears, mammograms, and immunizations
Blue Rx Complete Prescription Drug Coverage	
Rx Deductible	Medical Deductible applies; Real-time adjudication
Rx Copayments *(Includes Mandated Contraceptives)*	In-Network deductible, then 20% coinsurance
Rx Out of Pocket Maximum	Rx charges apply to medical OPM
Facility Services	
Inpatient Hospital Charges	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Inpatient Physician Charges	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Facility Services	
Outpatient Hospital Charges	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Outpatient Physician Charges	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Emergency Room Hospital Charges* **	In-Network: Deductible, then 10% coinsurance
Emergency Services	Out-of-Network: Deductible, then 10% coinsurance
Non-Emergency Services	Out-of-Network: Deductible, then 20% coinsurance
Diagnostic X-ray and Lab	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Maternity Care	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Mental Health / Chemical Dependency	
Inpatient	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Outpatient	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Office Visits	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance

	Wellmark Blue Cross Blue Shield Classic 100
Miscellaneous Services	
Infertility Treatment****	$25,000 lifetime maximum for transfer procedures
Durable Medical Equipment	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Ambulance	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Impacted Teeth	Outpatient Surgery for impacted teeth covered. Inpatient covered with concurrent medical condition.
Orthotic Devices	In-Network: Deductible, then 10% coinsurance; Out-of-Network: Deductible, then 20% coinsurance
Diabetic Education	Includes up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 mo period and up to 2 hours in each subsequent year.
BlueCard Services-Care Outside of Iowa	Provides enhanced benefits for services provided by participating providers outside of Iowa.
Monthly Rates	
Single	$577.54
2-Person	$1,115.05
Family	$1,677.25

Deductible will be waived for facility and practitioner billed preventive procedures performed at an Alliance Select Facility (inpatient or outpatient).

Plan allows for one routine physical examination per benefit period. A separate well-woman exam is also covered once per benefit period.

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 as that for an Office Visit.

*Lab or x-ray charges billed by an Alliance Select hospital in conjunction with office visits are NOT subject to deductible. **However, the following are subject to deductible:** EKG, EEG, ECG, MRI, MRA, CT, radiation therapy, and Ultrasounds (only with a medical diagnosis).

**Health maintenance exams (physicals) for school, sports, insurance, employment, and travel will not be covered. Physicals for routine preventive care continue to be covered.

***Mandated Contraceptives include oral, injected and implanted contraceptives, and contraceptive devices.

****Eligible infertility charges are covered as any other service and coinsurance will apply to annual out-of-pocket maximum.

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