MERCER

OKOBOJI COMMUNITY SCHOOL

Educators Group Plan Options

Rates Effective 7/1/2013 - 6/30/2014

	Wellmark Blue Cross Blue Shield Classic 500	Wellmark Blue Cross Blue Shield Classic 750	Wellmark Blue Cross Blue Shield Select 2000
Provider Network	Alliance Select	Alliance Select	Alliance Select
Calendar Year Deductible	$500 Single/$1,000 Family Annual Deductible	$750 Single/$1,500 Family Annual Deductible	$2,000 Single/$4,000 Family Annual Deductible
Coinsurance	10% in-network; 20% out-of-network	20% in-network; 30% out-of-network	20% in-network; 30% out-of-network
Out-of-Pocket Maximum	$1,000 Single/$2,000 Family Annual OPM	$1,500 Single/$3,000 Family Annual OPM	$4,000 Single/$8,000 Family Annual OPM
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physician (Office) Services			
Physician Office Visits*	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Chiropractic Benefit	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Allergy Testing	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Allergy Injections *(serum subject to deductible)*	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Preventive Care			
Routine Office Services *Annual Physical*** *Annual Well-Woman Exam* *Annual Mammogram* *Annual Vision Exam* *Immunizations / flu shots*	In-Network: Covered services paid at 100% Out-of-Network: Deductible, then 20% 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*	In-Network: Covered services paid at 100% Out-of-Network: Deductible, then 30% coinsurance *Deductible waived for out-of-network providers*
Well-Baby Care *(To age 7)*	In-Network: Covered services paid at 100% Out-of-Network: Ded waived, then 20% coinsurance	In-Network: Covered services paid at 100% Out-of-Network: Ded waived, then 30% coinsurance	In-Network: Covered services paid at 100% Out-of-Network: Ded waived, then 30% coinsurance
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 Preferred Prescription Drug Coverage* **			
Rx Benefit Period Deductible **Retail Copays** **Rx Out of Pocket Maximum**	Covered under health In-Network deductible applies 20% coinsurance after deductible	None $5 Tier 1 (generic) / $10 Tier 2 (brand name) None	$50 Single / $100 Family *(waived for generic)* $10-Tier 1 / $25-Tier 2 / $40-Tier 3 / $85 Specialty None
Facility Services			
Hospital Services **Inpatient/Outpatient**	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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 **Emergency Services** **Non-Emergency Services**	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance

	Wellmark Blue Cross Blue Shield Classic 500	Wellmark Blue Cross Blue Shield Classic 750	Wellmark Blue Cross Blue Shield Select 2000
Facility Services			
Diagnostic X-ray and Lab*	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Outpatient Therapy *(Speech, occupational, physical)*	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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
Mental Health / Chemical Dependency			
Inpatient	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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	In-Network: Deductible waived, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance	In-Network: Deductible waived, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Miscellaneous Services			
Infertility treatment**	$25,000 lifetime maximum	$25,000 lifetime maximum	$25,000 lifetime maximum
Durable Medical Equipment	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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	Out-of-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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	Outpatient Surgery for impacted teeth covered. Inpatient covered if medically necessary.	Outpatient Surgery for impacted teeth covered. Inpatient covered if medically necessary.	Outpatient Surgery for impacted teeth covered. Inpatient covered if medically necessary.
Orthotic Devices	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% 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
Diabetic Education	Includes up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 month 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 month 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 month period and up to 2 hours in each subsequent year.
Disease Management	Health Improvement tools to address chronic health conditions such as Diabetes, Asthma, COPD, Cardiac.	Health Improvement tools to address chronic health conditions such as Diabetes, Asthma, COPD, Cardiac.	Health Improvement tools to address chronic health conditions such as Diabetes, Asthma, COPD, Cardiac.
Same-Sex Domestic Partner	Covered as an eligible dependent (affidavit required).	Covered as an eligible dependent (affidavit required).	Covered as an eligible dependent (affidavit required).
Blue Card PPO	Provides enhanced benefits for services provided by participating provider outside of Iowa.	Provides enhanced benefits for services provided by participating provider outside of Iowa.	Provides enhanced benefits for services provided by participating provider outside of Iowa.
Monthly Rates			
Single	$467.22	$445.74	
Family	$1,261.55	$1,203.59	

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

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 never covered in full and do not apply to annual out-of-pocket maximum.*

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