MERCER

MT VERNON COMMUNITY SCHOOLS

Educators Group Plan Options

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

	Wellmark Blue Cross Blue Shield Classic 200	Wellmark Blue Cross Blue Shield Select 750	Wellmark Blue Cross Blue Shield Select 2000
Provider Network	Alliance Select	Alliance Select	Alliance Select
Calendar Year Deductible	$200 Single/$400 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	25% in-network; 35% out-of-network	20% in-network; 30% out-of-network
Out-of-Pocket Maximum	$500 Single/$1,000 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; 25% coinsurance Out of Network: Deductible, then 35% 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; 25% coinsurance Out of Network: Deductible, then 35% coinsurance	In-Network: Deductible waived; 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Doctor On Demand (Virtual Visits) - Doctor and Psychologist	10% coinsurance	25% coinsurance	20% coinsurance
Allergy Testing & Injections *(Serum subject to deductible)*	In-Network: Deductible waived; 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible waived; 25% coinsurance Out of Network: Deductible, then 35% 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 35% 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 35% 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 Complete Prescription Drug Coverage* **			
Rx Benefit Period Deductible **Retail Copays** **Rx Out of Pocket Maximum**	Covered under health with Real-Time Adjudication In-Network deductible applies Rx charges apply to medical OPM	$50 Single / $100 Family *(waived for generic)* $10-Tier 1 / $25-Tier 2 / $40-Tier 3 / $85 Specialty $1,500 Single / $3,000 Family Rx OPM	$50 Single / $100 Family *(waived for generic)* $10-Tier 1 / $25-Tier 2 / $40-Tier 3 / $85 Specialty $1,500 Single / $3,000 Family Rx OPM
Facility Services			
Hospital Services **Inpatient/Outpatient**	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% 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	Deductible, then 25% coinsurance Out-of-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance

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Facility Services			
Diagnostic X-ray and Lab*	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% coinsurance	In-Network: Deductible, then 20% 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 25% coinsurance Out-of-Network: Deductible, then 35% 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 25% coinsurance Out-of-Network: Deductible, then 35% 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 25% coinsurance Out-of-Network: Deductible, then 35% 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 25% coinsurance Out-of-Network: Deductible, then 35% coinsurance	In-Network: Deductible waived, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Miscellaneous Services			
Infertility treatment**	$25,000 lifetime maximum for transfer procedures	$25,000 lifetime maximum for transfer procedures	$25,000 lifetime maximum for transfer procedures
Durable Medical Equipment	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Ambulance	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% coinsurance	In-Network: Deductible, then 20% coinsurance Out-of-Network: Deductible, then 30% coinsurance
Impacted Teeth	Outpatient Surgery for impacted teeth covered. Inpatient covered with concurrent medical condition.	Outpatient Surgery for impacted teeth covered. Inpatient covered with a concurrent medical condition.	Outpatient Surgery for impacted teeth covered. Inpatient covered with a concurrent medical condition.
Orthotic Devices	In-Network: Deductible, then 10% coinsurance Out-of-Network: Deductible, then 20% coinsurance	In-Network: Deductible, then 25% coinsurance Out-of-Network: Deductible, then 35% 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.
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 providers outside of Iowa.	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	$821.46	$728.81	$651.89
Family	$1,988.26	$1,758.33	$1,567.43

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).

Select RX: 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.

**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.

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