Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons

Clarinda Community School District

$1,000 / $2,000 ALLIANCE SELECT HEALTH PLAN

BENEFIT	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single Family	**$1,000 / Single** **$2,000 / Family**	
Out-of-Pocket Maximums Single Family	**$2,000 / Single** **$4,000 / Family**	
Coinsurance	20%	40%
Lifetime Benefits Maximum	Unlimited	
Lifetime Infertility Maximum	$25,000	
Office Visit Services	**$25 Copay/$50 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible
Specific Preventive Care Includes: One routine physical per benefit period, a separate gynecological exam is also covered, related services, well-child care to age 7 and mammography.	Routine Health Care (age 7 or older)	
	Paid at 100% ***deductible & coinsurance waived***	**Paid at 100%** ***deductible & coinsurance waived***
	Well-Child Care (under age 7)	
	Paid at 100% ***deductible & coinsurance waived***	**Paid at 100%** ***deductible & coinsurance waived***
	Childhood Immunization (under age 7)	
	Paid at 100% ***deductible & coinsurance waived***	**Paid at 100%** ***deductible & coinsurance waived***
Inpatient Hospital Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Services		
Physician's Office	**$25 Copay/$50 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible
Emergency Room	$200 Copay Copay Waived if Admitted	$200 Copay Copay Waived if Admitted
Chiropractic Care	**$25 Copay/$50 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible
Maternity Care Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Infertility Treatment		
Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Office Visit	**$25 Copay/$50 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible
Mental Health/Chemical Dependency		
Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Office Services	**$25 Copay/$50 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible
Prescription Drug **Retail** Generic (30 Day Supply) Formulary (Brand PPO) (30 Day Supply) Non-Formulary (30 Day Supply) **Mail Order** Generic (90 Day Supply) Formulary (Brand PPO) (90 Day Supply) Non-Formulary (90 Day Supply)	 **$25 Copay Generic** **$50 Copay Brand Name** **$50 Copay Other Brand Name** **$50 Ded Single/$100 Ded Family (Waived for Generic)** **$50 Copay Generic** **$100 Copay Brand Name** **$100 Copay Other Brand Name**	
Rates 7/1/24 Single Family	 **$850.00** **$2,100.00**	

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment