

ANAMOSA COMMUNITY SCHOOL DISTRICT
EDUCATORS GROUP PLAN OPTIONS
 EFFECTIVE JULY 1, 2019 - JUNE 30, 2020

Medical	HDHP 2500 NE		Copay Select 2500		Blue Access 500		Copay Select 1500	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Alliance Select		Alliance Select		Wellmark Health Plan of Iowa		Alliance Select	
Deductible (Annual)	Employee \$2,500	Family \$5,000 *	\$2,500 \$5,000		\$500 \$1,000		\$1,500 \$3,000	
Out-of-Pocket Maximum (Annual)	Employee \$2,500	Family \$5,000 *	\$5,000 \$10,000		\$1,000 \$2,000		\$3,000 \$6,000	
Coinsurance	NA	NA	25%	35%	10%	NA	20%	30%
Office Visits - Primary Care	Deductible Applies		\$20 Copay	35% coinsurance after deductible	\$10 Copay	NA	\$15 Copay	30% coinsurance after deductible
Office Visits - Specialty Care	Deductible Applies		\$40 Copay	35% coinsurance after deductible	\$10 Copay	NA	\$30 Copay	30% coinsurance after deductible
Telehealth - Doctor on Demand	\$49 per virtual medical visit	NA	\$20 Copay	NA	\$10 Copay	NA	\$15 Copay	NA
Preventive Care: Adult Health Exam; Well Child to age 7; Well-Woman Services; Immunizations and Routine Vision Exam	0% In-Network	Deductible Applies	0% In-Network	35% coinsurance after deductible	0% In-Network	NA	0% In-Network	30% coinsurance after deductible
Hospitalization - Inpatient or Outpatient	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Emergency Room	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	\$50 Copay	NA	20% coinsurance after deductible	30% coinsurance after deductible
Mental Health / Chemical Dependency - Inpatient or Outpatient	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Ambulance	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Therapy (Speech, occupational, physical)	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Diagnostic X-Rays and Labs	Deductible Applies		25% coinsurance after deductible	35% coinsurance after deductible	10% coinsurance after deductible	NA	20% coinsurance after deductible	30% coinsurance after deductible
Infertility Benefits*	Up to Diagnosis only		\$25,000 lifetime maximum for transfer procedures		\$15,000 lifetime maximum for transfer procedures	NA	\$25,000 lifetime maximum for transfer procedures	
Orthotic Devices	Not Covered		25% coinsurance after deductible	35% coinsurance after deductible	Not Covered	NA	20% coinsurance after deductible	30% coinsurance after deductible

Pharmacy		HDHP 2500 NE	Copay Select 2500	Blue Access 500	Copay Select 1500
Wellmark Drug List		In-Network Blue Value Plus Rx	In-Network Blue Value Plus Rx	In-Network Blue Value Plus Rx	In-Network Blue Value Plus Rx
Rx Deductible (<i>Waived for Tier 1</i>)	Single	Medical Deductible applies	\$50	NA	\$50
Retail Pharmacy (30-day supply)	Family		\$100		\$100
	Tier 1		\$8	\$10	\$10
	Tier 2		\$35	\$25	\$25
	Tier 3		> \$50 or 50%, whichever is greater	\$40	\$40
Specialty Preferred			\$85	\$85	\$85
Specialty Non-Preferred			\$85	\$85	\$85
RX Out-of-Pocket Maximum	Single		\$1,500	\$1,500	\$1,500
	Family		\$3,000	\$3,000	\$3,000
Mail Order (90-day supply)	Tier 1		\$16	\$20	\$20
Rx Deductible applies; is waived for Tier 1	Tier 2	\$70	\$50	\$50	
	Tier 3	> \$100 or 50%, whichever is greater	\$80	\$80	
Premium Rates	Monthly	HDHP 2500 NE	Copay Select 2500	Blue Access 500	Copay Select 1500
Single		\$483.98	\$508.39	\$553.35	\$555.96
Family		\$1,158.99	\$1,220.01	\$1,332.40	\$1,338.94
Single - Annual		\$5,807.76	\$6,100.68	\$6,640.20	\$6,671.52
Family - Annual		\$13,907.88	\$14,640.12	\$15,988.80	\$16,067.28

NOTES:

NEW DRUG LIST FOR ALL EDUCATOR TRUST PLANS EFFECTIVE 7-1-19: BLUE VALUE PLUS RX DRUG FORMULARY - Tier 4 prescription coverage is excluded. Login to your myWellmark account to review your medical and Rx claims. www.wellmark.com

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 coinsurance % or Copay \$ as that for a Primary Office Visit.
HDHP: Member cost to use Doctor On Demand is \$49; or \$80 to \$189 (depending on length) for Psychologist. Coverage for psychiatry services has been added as well as Office Medication Management services. Deductible is waived.

An Iowa mandate was passed earlier this year that requires a carrier to *not discriminate between the same services provided in person or via telehealth. If a provider meets the necessary criteria and has the capabilities to provide a covered service via audio-visual means, it is required to be covered through health insurance.*

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

Pharmacy: If you use a nonparticipating pharmacy, you must pay the amount charged at the time of purchase, and the amount Wellmark reimburses you may be less than what you paid. You are responsible for this difference.

Specialty Copay Card Program: You must receive your Specialty Rx through Wellmark's Preferred Specialty Pharmacy, CVS/Caremark in order to utilize a Copay Card. Copay cards are direct-to-consumer incentives that reduce out-of-pocket costs for members. The cards are funded by manufacturers and built into the drug price. Only credits member's deductible and OPM with actual out-of-pocket costs at the pharmacy AFTER the application of the copay card. Member cost share unchanged (if it was \$150 copay, remains at \$150 copay. This program does not apply to financial-need based copay cards.

Rx Product Selection Penalty Rule - HMO Blue Access 500 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 except when the provider writes "Dispense as Written" (in this case, the member pays only the appropriate payment application).

+ Non-EmbeddedDeductible (NE): This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one family member or a combination of family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one family member or a combination of family members.

HDHP Notes: Non-Embedded Family Deductible; No 4th quarter deductible carry-over.

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply.