



Wellmark Blue Cross and Blue Shield Alliance Select ISEBA Plan Comparisons

Clarinda Community School District

\$750 / \$1,500 ALLIANCE SELECT HEALTH PLAN			\$1,500 / \$3,000 ALLIANCE SELECT HEALTH PLAN	
BENEFIT	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)	SELECT PROVIDERS (IN - NETWORK)	NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single Family	\$750 / Single \$1,500 / Family		\$1,500 / Single \$3,000 / Family	
Out-of-Pocket Maximums Single Family	\$1,500 / Single \$3,000 / Family		\$3,000 / Single \$6,000 / Family	
Coinsurance	20%	30%	20%	30%
Lifetime Benefits Maximum	Unlimited		Unlimited	
Lifetime Infertility Maximum	\$25,000		\$25,000	
Office Visit Services	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible	\$10 Copay deductible & coinsurance waived	30% 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)		Routine Health Care (age 7 or older)	
	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived
	Well-Child Care (under age 7)		Well-Child Care (under age 7)	
	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived
	Childhood Immunization (under age 7)		Childhood Immunization (under age 7)	
	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived	Paid at 100% deductible & coinsurance waived
Inpatient Hospital Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Emergency Services Physician's Office	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible
Emergency Room	\$200 Copay Copay Waived if Admitted	\$200 Copay Copay Waived if Admitted	\$200 Copay Copay Waived if Admitted	\$200 Copay Copay Waived if Admitted
Chiropractic Care	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible
Maternity Care Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Infertility Treatment Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible
Mental Health/Chemical Dependency Inpatient / Outpatient	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Office Services	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible	\$10 Copay deductible & coinsurance waived	30% coinsurance after deductible
Prescription Drug Retail Generic (30 Day Supply) Formulary (Brand PPO) (30 Day Supply) Non-Formulary (30 Day Supply)	\$10 Copay Generic \$20 Copay Brand Name		\$10 Copay Generic \$20 Copay Brand Name	
	\$50 Ded Single/\$100 Ded Family (Waived for Generic)		\$50 Ded Single/\$100 Ded Family (Waived for Generic)	
Mail Order Generic (90 Day Supply) Formulary (Brand PPO) (90 Day Supply) Non-Formulary (90 Day Supply)	\$20 Copay Generic \$40 Copay Brand Name		\$20 Copay Generic \$40 Copay Brand Name	
Rates 7/1/22 Single Family	\$750.00 \$1,823.00		\$725.00 \$1,773.00	

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 regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.