Medical Benefits

Claims Administrator: Wellmark (800) 774-0384 (www.wellmark.com)
Medical Network: Blue Select PPO
Pharmacy Network: BlueRx Complete

Monthly Costs[1]:

	Standard Rates		Wellness Rates[2]		Total
Coverage	Staff Cost	Employer Cost	Staff Cost	Employer Cost	Plan Cost
Individual Coverage	$107.48	$373.39	$85.25	$395.62	$480.87
Individual + 1 Coverage	$247.18	$858.83	$196.07	$909.94	$1,106.01
Family Coverage	$354.65	$1,232.24	$281.30	$1,305.59	$1,586.89

[1]Based on Full-time schedule. Part-time staff premiums are proportionally adjusted based on work schedule. Premiums for Part-time staff can be found in the back of this booklet.

[2]New employees receive the Wellness Rate. Employees hired on or after November 1, 2017, will receive the Wellness Rate (reduced medical insurance premiums) for the remainder of the 2017-2018 plan year and the 2018-2019 plan year without completing the Quality Health Survey or Preventive Care Form requirements. However, in order to retain the Wellness Rate for the 2019-2020 plan year, these employees must complete the Wellness Program requirements by March 1, 2019.

Summary of Medical Benefits

SERVICE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
	Member pays	Member pays
Provider Networks	When services are provided by a participating Blue Select PPO network provider, the provider will file claims on your behalf and has agreed to the allowed amount payment as payment in full less your deductible or copayments.	You still receive benefits when you use a non-participating provider, however, you may be responsible for filing your claims and payment to the provider. Any difference between the billed charge and the allowed amount is your responsibility. In addition, you are responsible for obtaining preadmission notification for inpatient hospital admissions and prior authorization for certain medical procedures.
Benefit Maximum (Per Plan Year)	Unlimited	
Lifetime Benefit Maximum	Unlimited	
Deductible (Per Plan Year) ▪ Individual ▪ Family	$500 $1,000	$1,500 $3,000
Annual Medical Out-of-Pocket Maximum ▪ Individual ▪ Family	$3,500 $7,000	$7,000 $14,000
	Includes deductible; coinsurance, office visit copays; excludes premiums, pre-service review penalties, balance-billed charges, and health care this plan doesn't cover.	
Annual Prescription Drug Program Out-of-Pocket Maximum (Accumulates with the medical) ▪ Individual ▪ Family	$3,500 $7,000	

SERVICE	PARTICIPATING PROVIDERS Member pays	NON-PARTICIPATING PROVIDERS Member pays
Services Received in a Physician's Office:		
Office Visits for illness or injuries ▪ Physician ▪ Specialist	 $20 co-pay per visit $20 co-pay per visit	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Physician Office Services *(laboratory, x-ray, therapy services, surgical procedures, etc.)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Preventive Care *(one time per benefit year)* ▪ Routine physicals	 Nothing	 Not covered
▪ Routine Cancer Screening (Mammograms, Pap Smears and Breast Exams for women, Prostate/PSA Exams for men)	Nothing	Not covered
▪ Routine Preventive Health Screening Tests, Lab and X-rays	Nothing	Not covered
▪ Immunizations	Nothing	Not covered
▪ Routine Hearing Exams	Nothing	Not covered
Well Child Care Visits (birth to age 6)	Nothing	Not covered
Preventive Colonoscopy, Sigmoidoscopy, and similar routine diagnostic procedures *(Per USPSTF Guidelines)*	Nothing	Not covered
Therapy Services: (Prior authorization is required for any services greater than 20 visits per calendar year)		
• Physical, Speech and Occupational Therapy (Physician's Office)	• $20 co-pay per visit	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
• Physical, Speech and Occupational Therapy (Outpatient Hospital)	• 20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
• Chiropractic Care	• 20% after the deductible up to the out-of-pocket maximum, then plan pays 100%	40 % after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Outpatient Services Received in a Hospital or Other Outpatient Setting:		
Outpatient Hospital Services (Lab tests, x-rays, kidney dialysis, radiation or chemotherapy, surgery, etc.)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Outpatient Mental Health and Chemical Dependency Care	Nothing for office visits; other outpatient services - 20% up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Emergency Room Services	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	Coverage is provided at the in-network level for *emergency services*
Physician services for outpatient surgery, anesthesia, obstetrics and in-hospital medical visits	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Inpatient Hospital Care (semi-private room):		
Inpatient Hospital Services (room and board, lab tests, x-rays, medication and medical supplies)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%. ***Preadmission Notification required*** *or you may be responsible for an additional portion of the bill.*

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Inpatient Mental Health and Chemical Dependency Care	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%. ***Preadmission Notification required*** *or you may be responsible for an additional portion of the bill.*
Physician services	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Transplant Services	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Other Medical Services:		
Durable Medical Equipment and Supplies *(Limitations may apply)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Ambulance Service	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Home Health Care *(40 visits/plan year maximum)*	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Skilled Nursing Care (60 days/plan year maximum)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Hospice Care (Lifetime maximum: Lesser of 6 months or $10,000)	20% after the deductible up to the out-of-pocket maximum, then plan pays 100%.	40% after the deductible up to the out-of-pocket maximum, then plan pays 100%.
Prescription Drug Benefit:		
At Designated Retail Pharmacies You pay your co-pay at time of purchase. *(Your co-pay applies to a maximum 30-day or 100-unit supply; insulin and diabetic supplies are covered.)*	• Over-the-counter generic non-sedating antihistamines [equivalents to Claritin, Allegra, Flonase, and Zyrtec], Rhinocort, and ulcer drugs (Prevacid and Prilosec OTC equivalents) - $0 copay with a written doctor's prescription • Over-the-counter aspirin to prevent cardiovascular disease, iron supplements to prevent anemia, fluoride tablets for children, erythromycin ophthalmic ointment for newborns, with physician's prescription • Tier 1 Drugs: Greater of $7/prescription or 10% • Tier 2: Greater of $25/prescription or 25% (Maximum $100) • Tier 3 and Tier 4: Greater of $50/prescription or 40% (Maximum $200) • If you choose to take a brand-name drug when a generic equivalent is available, you pay the brand-name copay plus the difference in cost between the brand and generic medication.	
Mail Order Pharmacy You can receive a 90-day supply of medications *through the Mail Order program*.	• Tier 1: Greater of $17.50/prescription or 10% • Tier 2: Greater of $62.50/Prescription or 25% (Maximum $250) • Tier 3 and Tier 4: Greater of $125/Prescription or 40% (Maximum $500)	Not covered
	• Pharmacy Engagement Program (per benefit year): If you are receive diabetic supplies and insulin listed as Tier 1 or Tier 2, or anti-cholesterol drugs listed as Tier 1 and you fill each prescription on time, you will pay the full copay for the first 90 day supply, 50% of the copay for the second 90 day supply, and $0 after three fills.	
Specialty Medications *(From Specialty Pharmacy Vendor. Applies to a 30-day supply)*	25% of the cost of the drug to a maximum of $150/prescription	Not covered