

Atlantic Community School District

Understanding your health benefits is the key to making educated health care decisions. Wellmark offers this summary to help you learn about your health plan coverage and the services that are typically covered or limited.

Your plan allows you to receive care from any health care provider you choose, and when you choose a health care provider who participates in the Alliance Select or BlueCard PPO[®] network, you reduce your out-of-pocket expenses. Need help finding an in-network provider or have specific benefit questions? Visit us and register at www.wellmark.com, refer to your coverage manual or call the Customer Service number on your ID card.

Health Plan Basics	In-Network Benefit	Out-of-Network Benefit
Benefit Period Deductible <i>Amount you pay in a calendar year before certain benefits are available. In-Network and Out-of-Network deductibles are separate.</i>	\$1,000 Single \$3,000 Family	\$2,000 Single \$6,000 Family
Copayment - Office Services <i>Amount you pay at the time you receive certain office-based services. (Deductible waived.)</i>	\$20 copayment	40% coinsurance after deductible
Copayment - Emergency Room <i>Amount you pay for emergency room and related facility and practitioner services.</i>	20% coinsurance after deductible	Non-Emergency Services: 40% coinsurance after deductible Emergency Services*: 20% coinsurance after deductible
Coinsurance <i>Percentage of medical expenses you pay after the deductible is met (unless otherwise noted), until you reach your out-of-pocket maximum.</i>	20% coinsurance	40% coinsurance
Out-of-Pocket Maximum (OPM) <i>Maximum amount you pay for covered services each calendar year. Deductible and coinsurance apply to OPM. Once your OPM is satisfied, most services are covered in-full through the end of the calendar year. In-Network and Out-of-Network OPM is separate. (Copayments do not apply to OPM.)</i>	\$2,000 Single \$4,000 Family	\$4,000 Single \$8,000 Family
Lifetime Limits on Essential Benefits <i>Essential benefits: a set of health care service categories defined as "essential" by the Affordable Care Act (ACA). Examples of a few ACA defined categories include: emergency services, hospitalization, maternity and newborn care, prescription drugs, and preventive and wellness services.</i>	Unlimited	
Other Allowable Lifetime Limits <i>Maximum amount each covered family member is eligible to receive under this plan, for non-essential covered services, in his/her lifetime.</i>	Infertility – Limited to \$15,000 per lifetime; coinsurance does not apply to out-of-pocket maximum.	
Annual Limits on Essential Benefits	None	
Other Allowable Annual Limits	None	
Other Allowable Annual Day/Visit Limits	Nursing Facility Care – Limited to 90 days per benefit period. Hospice Respite – Limited to 15 days inpatient/ 15 days outpatient per lifetime.	
Care Outside Iowa – BlueCard[®] program	Provides coverage nationwide by using providers of the Blue Cross and/or Blue Shield plan in the area where you receive services. You must use an in-network provider to receive the highest benefit level.	
*Out-of-Network Emergency Services	Covered emergency services for medical conditions that a prudent layperson expects would otherwise result in death, permanent disability, or severe pain will be reimbursed as though services were received from a participating provider. You are responsible for any excess of the provider's billed charge over our settlement amount.	

Covered Benefits <i>When you receive these services, you pay:</i>	In-Network Benefit	Out-of-Network Benefit
Office Services Physician services, X-rays, labs, etc.	\$20 copayment	40% coinsurance after deductible
Independent Lab Services	20% coinsurance	40% coinsurance after deductible
Chiropractic Care Office Services	\$20 copayment	40% coinsurance after deductible
Preventive Care Services <ul style="list-style-type: none"> Physical exam (one per benefit period; includes separate gynecological exam) Immunizations X-ray/labs Mammogram (one per benefit period) Pap smears Prostate screening Well-child care Smoking cessation counseling Obesity counseling/screening Child hearing and vision screening 	No member cost share	40% coinsurance after deductible
Mental Health/Chemical Dependency <ul style="list-style-type: none"> Office visit Independent Lab Outpatient services Inpatient services 	\$20 copayment No cost share 20% coinsurance after deductible 20% coinsurance after deductible	40% coinsurance after deductible
Maternity Care <ul style="list-style-type: none"> Physician services Facility services 	20% coinsurance after deductible	40% coinsurance after deductible
Contraceptives Injected and implanted contraceptives and contraceptive devices. (oral contraceptives are covered under your drug program, see Prescription Drugs) <ul style="list-style-type: none"> Office services Facility services 	\$20 copayment 20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs	Covered under Blue Rx Preferred SM prescription drug program. Please refer to your drug plan benefit summary for more information.	
Dental Treatment For accidental injury only, if completed within 12 months of the injury.	20% coinsurance after deductible	40% coinsurance after deductible
Physician Services <ul style="list-style-type: none"> Inpatient facility care Outpatient facility care 	20% coinsurance after deductible	40% coinsurance after deductible
Facility Services (deductible waived for in-network preventive care) <ul style="list-style-type: none"> Inpatient hospital Outpatient hospital Nursing facility 	20% coinsurance after deductible	40% coinsurance after deductible
Ambulance	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room (if admitted, see Facility Services) <ul style="list-style-type: none"> Facility services Physician services 	20% coinsurance after deductible	Non-Emergency Services: 40% coinsurance after deductible Emergency Services*: 20% coinsurance after deductible
Home/Durable Medical Equipment (deductible waived for in-network prosthetic limbs)	20% coinsurance after deductible	40% coinsurance after deductible
Home Health Care	20% coinsurance after deductible	40% coinsurance after deductible
Hospice Services	20% coinsurance after deductible	40% coinsurance after deductible

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Prescription Drug Plan Benefit Summary Two-Tier Copay Plan Non-Grandfathered Drug Plan

Atlantic Community School District

With Blue Rx Preferred, you get convenient access to a large pharmacy network that includes both national retail chains and independent pharmacies.

You are enrolled in a prescription drug plan that uses tiers. How much you pay for a prescription depends on a drug's tier, whether the drug is generic or brand-name. The higher the tier number, the higher the copayment.

Annual Deductible	Tier 1 Generic Drug Copayment	Tier 2 Brand-Name Drug Copayment	Specialty Self-Administered Drugs
\$0	\$10	\$20	\$100

Visit www.wellmark.com for additional prescription drug information.

Tier Definitions

- **Tier 1:** Consists of most generic drugs. Tier 1 drugs have the lowest copayments.
- **Tier 2:** Consists of preferred brand-name drugs and branded generic drugs. Many drugs appear on this tier because they have no generic equivalent. You will pay more for Tier 2 drugs than for Tier 1 drugs.

If you purchase a Tier 2 drug when an A-rated generic drug is available, you are responsible for your copayment amount plus any difference in price between the billed charge for the generic drug and the billed charge for the brand-name drug. You are responsible for this difference unless your provider has specified that you must take the brand-name drug (DAW).

If the pharmacy's charge is less than the copayment amount, you pay only the pharmacy charge.

All drugs must be self-administered according to the instructions given by the practitioner and the pharmacist.

Drug Quantities

- Mail order maintenance prescriptions: 90-day supply for one copayment.
- Maintenance prescriptions purchased at a participating retail pharmacy: 90-day supply for three copayments
- All other prescriptions: 30-day supply for one copayment

Covered Services

- Most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription"
- Drugs dispensed by a pharmacist from a licensed retail pharmacy
- Prescription drugs that are prescribed by a practitioner legally authorized to prescribe
- Insulin and these insulin supplies: needles, syringes, test strips, and lancets
- Contraceptives
- Specialty drugs, typically administered by the member; limited to a 30-day supply per copayment; see Specialty Drug List on www.wellmark.com
- Tobacco cessation drugs
- Prenatal vitamins
- Immunizations and vaccines that are covered under health are also covered when administered at a pharmacy.
- Certain preventive drugs, immunizations and vaccines, as recommended by the US Preventive Services Task Force, will be covered at no member cost share.

Non-Covered Drugs and Services

- Contraceptive implants, injections, devices and related services (These services may be covered under the health program.)
- Cosmetic drugs
- Drugs determined to be abused or otherwise misused by you
- Drugs that require a prescription by state law but not federal law
- Immunizations not covered under health
- Infertility drugs
- Investigational drugs
- Irrigation solutions and supplies
- Nutritional supplements
- Over-the-counter products including nutritional dietary supplements
- Self-help or self-cure programs
- Therapeutic devices or medical appliances
- Weight-reduction drugs

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Benefit Summary Alliance Select HSA PPO Plan Non-Grandfathered Health Plan

An Independent Licensee of the Blue Cross and Blue Shield Association

Atlantic Community School District

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Your Alliance Select health plan qualifies you to open a Blue Priority Health Savings Account (HSA) to save and pay for medical expenses. HSA dollars can be used to help pay covered health care expenses until the deductible is met. The health plan takes care of covered medical expenses exceeding the deductible.

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Health Plan Basics	In-Network Benefit	Out-of-Network Benefit
Benefit Period Deductible <i>Amount you pay in a calendar year before benefits are available.</i>	\$1,500 Single \$3,000 Family	\$3,000 Single \$6,000 Family
Coinsurance - Office Services <i>Percentage you pay at the time you receive certain office-based services.</i>	20% coinsurance	40% coinsurance
Coinsurance - Emergency Room <i>Percentage you pay for emergency room and related facility and practitioner services.</i>	20% coinsurance after deductible	Non-Emergency Services: 40% coinsurance after deductible Emergency Services*: 20% coinsurance after deductible
Coinsurance <i>Percentage of medical expenses you pay after the deductible is met (unless otherwise noted), until you reach your out-of-pocket maximum.</i>	20% coinsurance	40% coinsurance after deductible
Out-of-Pocket Maximum (OPM) <i>Maximum amount you pay for covered services each calendar year. Deductible and coinsurance apply to OPM. Once your OPM is satisfied, most services are covered in-full through the end of the calendar year.</i>	\$3,000 Single \$6,000 Family	\$6,000 Single \$12,00 Family
Lifetime Limits on Essential Benefits <i>Essential benefits: a set of health care service categories defined as "essential" by the Affordable Care Act (ACA). Examples of a few ACA defined categories include: emergency services, hospitalization, maternity and newborn care, prescription drugs, and preventive and wellness services.</i>	Unlimited	
Other Allowable Lifetime Limits <i>Maximum amount each covered family member is eligible to receive under this plan, for non-essential covered services, in his/her lifetime.</i>	Infertility – Limited to \$15,000 per lifetime; coinsurance does apply to out-of-pocket maximum.	
Annual Limits on Essential Benefits	None	
Other Allowable Annual Limits	None	
Other Allowable Annual Day/Visit Limits	Nursing Facility Care – Limited to 90 days per benefit period. Hospice Respite – Limited to 15 days inpatient/15 days outpatient per lifetime.	
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Covered Benefits <i>When you receive these services, you pay:</i>	In-Network Benefit	Out-of-Network Benefit
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Mental Health/Chemical Dependency <ul style="list-style-type: none"> Office visit Independent Lab Outpatient Services Inpatient Services 	20% coinsurance after deductible	40% coinsurance after deductible
Maternity Care <ul style="list-style-type: none"> Physician services Facility services 	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs/Contraceptives	Covered under health at the in-network deductible level.	
Dental Treatment For accidental injury only, if completed within 12 months of the injury.	20% coinsurance after deductible	40% coinsurance after deductible
Physician Services <ul style="list-style-type: none"> Inpatient facility care Outpatient facility care 	20% coinsurance after deductible	40% coinsurance after deductible
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