Central Lyon Community School
Medical Plan Options

Renewal Date: July 1, 2019

	Option 1 Wellmark BCBS of IA Alliance Select $1,000 Plan		Option 2 Wellmark BCBS of IA Alliance Select $2,000 Plan		Option 3 Wellmark BCBS of IA Alliance Select $5,000 Plan	
Effective Date	7/1/2019		7/1/2019		7/1/2019	
Deductible	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	$1,000	$2,000	$2,000	$4,000	$5,000	$10,000
Family	$2,000	$6,000	$4,000	$8,000	$10,000	$20,000
Out of Pocket Maximum						
Individual	$2,500	$10,000	$4,000	$8,000	$6,000	$12,000
Family	$5,000	$10,000	$8,000	$16,000	$12,000	$24,000
Coinsurance (Member Pays)	20%	40%	20%	40%	20%	40%
Office Visit / Services						
Primary Care Physician	$35	Deductible then Coinsurance	$35	Deductible then Coinsurance	$35	Deductible then Coinsurance
Specialist	$70	Deductible then Coinsurance	$70	Deductible then Coinsurance	$70	Deductible then Coinsurance
Telehealth	$35	NA	$35	NA	$35	NA
Preventive Care	100%	Deductible then Coinsurance	100%	Deductible then Coinsurance	100%	Deductible then Coinsurance
Chiropractic	$35	Deductible then Coinsurance	$35	Deductible then Coinsurance	$35	Deductible then Coinsurance
Emergency Room	$300	In-Network Benefits Apply	$300	In-Network Benefits Apply	$300	In-Network Benefits Apply
Urgent Care	$35	$35	$35	$35	$35	$35
Mental Health / Substance Abuse						
Inpatient Services	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Outpatient Services						
Office visit / Services	$35/Deductible then Coinsurance	Deductible then Coinsurance	$35/Deductible then Coinsurance	Deductible then Coinsurance	$35/Deductible then Coinsurance	Deductible then Coinsurance
Prescription Drug Benefit					$100 Single / $200 Family Deductible	
Retail	30-day supply		30-day supply		30-day supply	
Tier I	$12	Not Covered	$12	Not Covered	$12	Not Covered
Tier II	$40	Not Covered	$40	Not Covered	$40	Not Covered
Tier III	$70	Not Covered	$70	Not Covered	$70	Not Covered
Specialty	50% Coinsurance	Not Covered	50% Coinsurance	Not Covered	Deductible then 50% Coinsurance	Not Covered

NOTE: Please refer to your Summary of Benefits and Coverage documents for more details on the plan designs.

Health Insurance Benefit Selection

I select the following Health Plan Option:

_____ Option #1: ($1,000/$2,000 Plan) _____Single _____ Employee/Child(ren) _____ Employee/Spouse _____ Family

_____ Option #2: ($2,000/$4,000 Plan) _____Single _____ Employee/Child(ren) _____ Employee/Spouse _____ Family

_____ Option #3: ($5,000/$10,000 Plan) _____Single _____ Employee/Child(ren) _____ Employee/Spouse _____ Family

_____ I elect to waive health insurance at this time.

Name: _____ **Signature:** _____ **Date:** _____

(Please Print)