



Gilbert Community School District

Benefit Elections Due by May 29, 2019

Wellmark BlueCross BlueShield Plans 2019-2020

	Option 1		Option 2			Option 3		
	Wellmark BCBS		Wellmark BCBS			Wellmark BCBS		
	Alliance Select		Blue Choice			Alliance Select		
	OBS #116409-149/116409-150		OBS #116409-153/116409-154			OBS #116409-151/116409-152		
	In Network	Out-of-Network	Level 1 Benefit	Level 2 Benefit	Level 3 Benefit	In Network	Out-of-Network	
Deductible	\$1,000 Single/\$2,000 Family	\$2,000 Single/\$4,000 Family	\$1,000 Single/\$2,000 Family			\$2,000 Single/\$4,000 Family	\$3,000 Single/\$6,000 Family	\$6,000 Single/\$12,000 Family
Coinsurance	80%/20%	60%/40%	80%/20%			60%/40%	100%/0%	100%/0%
Out-of-Pocket Maximum	\$2,000 Single/\$4,000 Family	\$4,000 Single/\$8,000 Family	\$2,000 Single/\$4,000 Family			\$4,000 Single/\$8,000 Family	\$3,000 Single/\$6,000 Family	\$6,000 Single/\$12,000 Family
Ambulance Expense	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	
Office Visit Copay	\$25 PCP/\$40 Specialist	Deductible/Coinsurance	\$25	\$40	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	
Preventive Care	Copay is waived	Deductible/Coinsurance	Copay is waived	\$40	Deductible/Coinsurance	Not subject to Deductible*	Deductible/Coinsurance	
Well Child Care	Copay is waived	Deductible/Coinsurance	Copay is waived	\$40	Deductible/Coinsurance	Not subject to Deductible	Deductible/Coinsurance	
Urgent Care Copay	\$25 (if services billed as office visit)	Deductible/Coinsurance	\$25 (if services billed as office visit)	\$40 (if services billed as office visit)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	
Emergency Room Copay	\$75	Deductible/Coinsurance	\$100			Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic	\$25 Subject to Care Management	Deductible/Coinsurance	\$25 Subject to Care Management			Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Lifetime Maximum	Unlimited		Unlimited			Unlimited		
	Prescription Drugs		Prescription Drugs			Prescription Drugs		
Pharmacy	Copay: \$15/\$30/\$45 & 2 copays for mail order	NA	Copay: \$15/\$30/\$45 & 2 copays for mail order			NA	Deductible/Coinsurance	NA
	Mental Health & Substance Abuse Services MHCD**		Mental Health & Substance Abuse Services MHCD**			Mental Health & Substance Abuse Services MHCD**		
Outpatient	\$25 Office visit or Deductible/Coinsurance	Deductible/Coinsurance	\$25 Office visit or Deductible/Coinsurance	\$40 Office visit or Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	
Inpatient	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Ded. applies then plan pays	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	
	2019-2020 Rates		2019-2020 Rates			2019-2020 Rates		
Employee	\$680.68		\$623.29			\$525.53		
Employee/Spouse	\$1,399.15		\$1,279.82			\$1,076.55		
Employee/Child(ren)	\$1,291.71		\$1,181.64			\$994.15		
Family	\$1,708.09		\$1,562.12			\$1,313.48		

*Does not include routine vision exam
 **MHCD treated as any other illness

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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.