Audubon CSD
Wellmark Blue Cross and Blue Shield ISEBA Plan Comparisons

BENEFIT	$1,500 / $3,000 ALLIANCE SELECT HEALTH PLAN — SELECT PROVIDERS (IN - NETWORK)	$1,500 / $3,000 ALLIANCE SELECT HEALTH PLAN — NON-SELECT PROVIDERS (OUT - OF - NETWORK)	$3,500 / $7,000 HEALTH SAVINGS ACCOUNT — SELECT PROVIDERS (IN - NETWORK)	$3,500 / $7,000 HEALTH SAVINGS ACCOUNT — NON-SELECT PROVIDERS (OUT - OF - NETWORK)	$2,000 / $4,000 Blue Choice Plan — SELECT PROVIDERS (IN - NETWORK)	$2,000 / $4,000 Blue Choice Plan — NON-SELECT PROVIDERS (OUT - OF - NETWORK)
Benefit Period Deductible Single / Family	**$1,500 / Single** **$3,000 / Family**		**$3.500 / Single** **$7,000 / Family**		**$2,000 / Single** **$4,000 / Family**	**$4,000 / Single** **$8,000 / Family**
Out-of-Pocket Maximums Single / Family	**$4,000 / Single** **$8,000 / Family**		**$3,500 / Single** **$7,000 / Family**		**$4,000 / Single** **$8,000 / Family**	**$8,000 / Single** **$16,000 / Family**
Coinsurance	20%	40%	0%	0%	20%	30%
Lifetime Benefits Maximum	Unlimited		Unlimited		Unlimited	
Lifetime Infertility Maximum	$25,000		$15,000		Up to Diagnosis Only	
Office Visit Services	**$20 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% coinsurance after deductible	**$25 PCP Copay/$40 Specialist 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, mammography, one per benefit period.	**Routine Health Care (age 7 or older)** **Paid at 100%** deductible & coinsurance waived **Well-Child Care (under age 7)** **Paid at 100%** deductible & coinsurance waived **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	**Routine Health Care (age 7 or older)** **Paid at 100%** deductible & coinsurance waived **Well-Child Care (under age 7)** **Paid at 100%** deductible & coinsurance waived **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	**Routine Health Care (age 7 or older)** **Paid at 100%** deductible & coinsurance waived **Well-Child Care (under age 7)** **Paid at 100%** deductible & coinsurance waived **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	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Emergency Services Physician's Office	**$20 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	**$25 PCP Copay/$40 Specialist Copay** deductible & coinsurance waived	30% coinsurance after deductible
Emergency Room	$200 copay Waived if admitted	$200 copay Waived if admditted	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	$200 copay Waived if Admitted	30% coinsurance after deductible
Chiropractic Care	**$20 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	**$25 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	30% coinsurance after deductible
Maternity Care Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Infertility Treatment Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Office Visit	**$20 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	**$25 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	30% coinsurance after deductible
Mental Health/Chemical Dependency Inpatient / Outpatient	20% coinsurance after deductible	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	20% coinsurance after deductible	30% coinsurance after deductible
Office Services	**$20 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	40% coinsurance after deductible	0% Coinsurance *after deductible*	0% Coinsurance *after deductible*	**$25 PCP Copay/$40 Specialist Copay** ***deductible & coinsurance waived***	30% coinsurance after deductible
Prescription Drug* Generic Tier 1 / Brand Tier 2 / Other Brand Tier 3	$10 Copay $30 Copay $50 Copay Separate RX OOP $2,850/$5,700 $50 single/$100 family deductible - waived for generic		0% Coinsurance *after deductible*		$10 Copay $30 Copay $50 Copay Separate OOP Maximum $2,850/$5,700 $50 single/$100 family deductible - waived for generic	
Monthly Rates 7-1-20 Single / Family	$569.85 $1,424.60		$449.68 $1,124.19		$526.20 $1,315.47	

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.

*Mail order maintenance prescriptions: 90-day supply for two copayments

*Maintenance prescriptions purchased at Advance Rx pharmacy: 90-day supply for three copayments

*All other prescriptions: 30-day supply for one copayment