Indianola CSD

2023-2024 INSURANCE PLAN INFORMATION

Open Enrollment Period for Completing Paperwork: April 24, 2023 - May 8, 2023	Option 1	Option 2	Option 3
Health Carrier - Wellmark BCBS			
Plan Name and Network	PPO $5,000 HDHP	PPO $2,500	PPO $1,000
Medical - Network and Non-Network Providers (Single/Family)	$5,000/$10,000	$2,500/$5,000	$1,000/$2,000
Coinsurance - After Deductible			
Network Providers	100%/0%	80%/20%	90%/10%
Non-Network Providers	100%/0%	60%/40%	80%/20%
Annual Out-of-Pocket Maximums			
Medical - Network and Non-Network Providers (Single/Family)	$5,000/$10,000	$5,000/$10,000	$2,000/$4,000
Prescription (Single/Family)	Included in Medical Deductible	$1,850/$3,700	$2,000/$4,000
Office Services			
Network Providers	Subject to Deductible	$20 copay for PCP $40 copay for non-PCP	$25 copay for PCP $50 copay for non-PCP
Non-Network Providers	Subject to Deductible	Deductible, then coinsurance	Deductible, then coinsurance
Doctor On Demand	$10 copay	$10 copay	$10 copay
Prescription Drugs	Subject to Deductible	Deductible: $50 single/$100 Family (Deductible waived for Tier 1) Tier 1: $10 Tier 2: $30 Tier 3: $50 Specialty: $100	Deductible: $50 single/$100 Family (Deductible waived for Tier 1) Tier 1: $15 Tier 2: $40 Tier 3: $60 Specialty: $100
Inpatient or Outpatient Hospital/Physician Services	Subject to Deductible	Deductible, then coinsurance	Deductible, then coinsurance
Emergency Room *Copay waived if admitted immediately following visit*	Subject to Deductible	$100 copay	$200 copay
Preventive Care	***Deductible Waived***	Deductible, coinsurance, & copay waived	Deductible, coinsurance, & copay waived
Mental Health and Chemical Dependency	Covered	Covered	Covered
Chiropractor Services	Subject to Deductible	$20 copay	$25 copay

****Employee receives cash when enrolling in single coverage on Option 1. Staff contributing to an HSA would receive up to $100 district match in $25 increments.**

	Option 1 Monthly Premium			Option 2 Monthly Premium		Option 3 Monthly Premium	
	Total Cost	Employee Cost	Cash**	Total Cost	Employee Cost	Total Cost	Employee Cost
Single	$474.66	$0.00	$167.44	$642.10	$0.00	$737.92	$95.82
Single plus One	$905.22	$263.12		$1,224.46	$582.36	$1,407.18	$765.08
Family	$1,257.84	$615.74		$1,669.46	$1,027.36	$1,992.38	$1,350.28

Annual Benefit - Deductible is Calendar Year (January 1 - December 31)

Indianola Community School District

	Delta Dental of Iowa Monthly Premium		Avesis Vision Monthly Premium	
	Total Cost	Employee Cost	Plan Type	Employee Cost
Single	$29.90	$0.00	Single	$12.24
Single plus One	$59.92	$30.02	Single plus One	$24.02
Family	$120.00	$90.10	Family	$31.82
	Plan Deductible is Calendar Year (January 1 - December 31)		Plan Year July 1 - June 30	

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.