



Gilbert Community School District Wellmark BlueCross BlueShield Plans 2024-2025

Benefit Elections Due by May 6, 2024
Enroll Through the EASE Portal
April 22 through May 6

2024: NEW PARTIALLY SELF-FUNDED DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM HIGHLIGHTED IN YELLOW BELOW

	Option 1		Option 2			Option 3		
	Wellmark BCBS		Wellmark BCBS			Wellmark BCBS		
	Alliance Select		Blue Choice			Alliance Select- <i>non-embedded</i> **		
	This is a high level overview of Options 1 and 2. See notes below regarding Partial Self-Funding.							
	In Network		Out-of-Network		Level 1 Benefit		Level 2 Benefit	
Deductible	\$2,000 Single/\$4,000 Family	\$4,000 Single/\$8,000 Family	\$2,000 Single/\$4,000 Family		\$4,000 Single/\$8,000 Family		\$5,000 Single/\$9,450 Family	\$7,000 Single/\$14,000 Family
Coinsurance	80%/20%		60%/40%		80%/20%		60%/40%	
Out-of-Pocket Maximum	\$4,000 Single/\$8,000 Family	\$8,000 Single/\$16,000 Family	\$4,000 Single/\$8,000 Family		\$8,000 Single/\$16,000 Family		\$5,000 Single/\$9,450 Family	\$7,000 Single/\$14,000 Family
Office Visit Copay	\$25 PCP/\$40 Specialist		Deductible/Coinsurance		\$25 PCP/\$40 Specialist	\$40 PCP/\$40 Specialist	Deductible/Coinsurance	
Preventive and Well Child	Copay is waived*		Deductible/Coinsurance		Copay is waived		Not Covered	
Urgent Care Copay	\$25 (if services billed as office visit)		Deductible/Coinsurance		\$40 (if services billed as office visit)		Deductible/Coinsurance	
Emergency Room Copay	\$75				\$100		Deductible/Coinsurance	
Chiropractic	\$25 Subject to Care Management		Deductible/Coinsurance		\$25 Subject to Care Management		Deductible/Coinsurance	
Lifetime Maximum	Unlimited				Unlimited		Unlimited	
	Prescription Drugs				Prescription Drugs			
Pharmacy	Copay: \$15/\$30/\$45 & 2 copays for mail order				Copay: \$15/\$30/\$45 & 2 copays for mail order		Deductible/Coinsurance	
	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	
Inpatient	Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance		Deductible/Coinsurance	
	2024-2025 Rates				2024-2025 Rates		2024-2025 Rates	
Employee	\$740.60				\$666.81		\$540.78	
Employee/Spouse	\$1,523.74				\$1,370.31		\$1,108.25	
Employee/Child(ren)	\$1,406.63				\$1,265.11		\$1,023.39	
Family	\$1,860.49				\$1,672.81		\$1,352.27	

NEW as of July 1, 2024, the District will self-fund a portion of your deductible and medical out-of-pocket expense. The plans purchased from Wellmark BCBS for Option 1 and Option 2 will have a \$4,000 in-network single deductible and a \$8,000 medical out-of-pocket maximum. The District will fund your eligible in-network deductible expense above \$2,000 for any one person or family member and your eligible medical out-of-pocket above \$4,000 for one person or family member. Member out-of-pocket expense is higher on out-of-network charges. **MORE INFORMATION IS IN EASE - COME TO A MEETING TO LEARN MORE DETAIL.** CALL BENEFIT SOURCE, INC. BEFORE PAYING EXPENSES OTHER THAN COPAYMENTS.

** NOTE- HDHP- **OPTION 3**: You must pay all costs from providers up to the deductible amount before the plan begins to pay. If you have family members on the plan, the overall family deductible must be met before the plan begins to pay. See Wellmark Summary of Benefits and Coverage in EASE for more detail.



CONTACT INFORMATION: Debbie@BenefitSourceInc.com or Jessica@BenefitSourceInc.com at (866)526-6581

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.