Family Medicine of Mt Pleasant PC

Wellmark Health Plan of Iowa: 12/01/2020 Open Enrollment

	In-Network Only
Plan Name/ Network	CompleteBlue 4000 HMO
Office Visit including Chiropractic	$40 PCP / $90 Specialist Copay Virtual Visit: $40 Copay
Deductible	$4,000 Single / $8,000 Family
Coinsurance	70% / 30%
Out-of-Pocket	$8,150 Single / $16,300 Family
Lifetime Maximum	Unlimited
Adult Routine Exam	Covered - 100%
Mental Health/Substance Abuse	Covered as any other illness.
Emergency Room Visits	$500 Copay
Inpatient Hospital	Deductible + 30%
Outpatient Hospital	Deductible + 30%
Rx Benefits	Tier 1 / Tier 2 / Tier 3 / Preferred Specialty / Non-Preferred Specialty
Retail: 30 day supply	$30 / $60 / $125 / $150 / $500
Mail Order: 90 day supply	3 Copays - Specialty excluded
Annual Vision Exam	Child only: Exam: 100% / Glasses: $130 Allowance
Rate Guarantee	12 months

Employee Name: _____

*I wish to waive medical coverage (sign & date here):*_____

I wish to enroll in medical coverage (sign & date here):_____

Enrollee Name	Enrollee Age and Relationship	Premium per Enrollee *(from age rate chart)*
Total Per Pay Period (Pre-tax) Contribution		

Enrollment form instructions: **Every benefit eligible employee is required to complete and submit this form to Dave Weiss by Friday, November 13th.**

* If you are waiving coverage, simply print your name in on the first line and then sign and date beside this waiver option.

* If you are enrolling in coverage, please print your name in the first line and sign and date beside the enrollment indication. You will then want to complete the enrollment and contribution chart above by filling in the name, age, and relationship of each enrollee. Your premiums are age rated per person, so you will find the premium per enrollee and relationship on the age rate chart on page two. Insert each rate in the premium column on the chart above and total to determine your per pay period cost.

* Please note, if you were on the plan last year, plan changes have been indicated in red on the summary.

* If you are newly enrolling or adding new/additional dependents to your enrollment this year, please complete the coordinating Wellmark enrollment form.

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Vision and Dental Benefit Enrollment Options: 12/01/2020

Employee Name: _____

	Dental Benefits: Delta Dental of Iowa
Network Name	Delta Dental Premier - Plan B Prime w/ Ortho
Network Availability	8 general dentists within 15 miles
Calendar Year Benefit	$2,000
Deductible	$25 per enrollee waived for D&P
Coinsurance	
Preventive	100% / 0%
Basic	80% / 20%
Major	50% / 50%
Vision Discount Card	Included
Ortho Lifetime Benefit	*$1,500
Orthodontia	* 50% / 50%
Annual Rollover	Included
Adult	$19.80 per person per pay period
Child (up to age 20)	$15.49 per person per pay period

I wish to waive dental coverage (sign & date here):_____

I wish to enroll in dental coverage (sign & date here): _____

(Then complete the chart below and the Delta Dental enrollment form)

	Vision Benefits: VSP
Network Name	VSP Choice
Network Availability	7 clinics within 25 miles
Examinations / Frequency	$10 copay / 1 exam every 12 months
Lenses / Frequency ***Single vision, Lined bifocal, Lined trifocal, Lenticular***	Covered in full after $30 copay / every 12 months
Frames / Frequency	$130 retail allowance after $30 copay / every 12 months
Contact Lenses / Frequency	$130 retail allowance after $30 copay / every 12 months (in place of lenses & frames)
Employee	$4.95 per pay period
Employee + Spouse	$7.92 per pay period
Employee + Child(ren)	$8.09 per pay period
Employee + Family	$13.04 per pay period

I wish to waive vision coverage (sign & date here):_____

I wish to enroll in vision coverage (sign & date here): _____

(Then complete the chart below and the VSP enrollment form)

Enrollee Name, age and relationship	Dental Premium (per person)	Vision Premium (by election level)
Total Per Pay Period (Pre-tax) Contribution		

Enrollment form instructions: **Every benefit eligible employee is required to complete and submit this form to Dave Weiss by Friday, November 13th.**

* If you are waiving coverage, simply print your name in on the first line and then sign and date beside this waiver option for vision and dental.

* If you are enrolling in coverage, please print your name in the first line and sign and date beside the enrollment indication. You will then want to complete the enrollment and contribution chart above by filling in the name, age, and relationship of each enrollee. Dental premiums are per enrollee by age, vision premiums are composite rated by your election level.

* If you are enrolling you will also need to complete the coordinating carrier enrollment form for VSP and/or Delta Dental.

		Employee		Spouse/Dependent
Age	Full Monthly Premium	Clinic Pays Per Month	Employee Pays Per Pay Period	Employee Pays Per Pay Period2
0-14	$238.14	214.33	10.99	109.91
15	$259.30	233.37	11.97	119.68
16	$267.40	240.66	12.34	123.42
17	$275.49	247.94	12.71	127.15
18	$284.21	255.79	13.12	131.17
19	$292.92	263.63	13.52	135.19
20	$301.95	271.76	13.94	139.36
21	$311.29	280.16	14.37	143.67
22	$311.29	280.16	14.37	143.67
23	$311.29	280.16	14.37	143.67
24	$311.29	280.16	14.37	143.67
25	$312.53	281.28	14.42	144.24
26	$318.76	286.88	14.71	147.12
27	$326.23	293.61	15.06	150.57
28	$338.37	304.53	15.62	156.17
29	$348.33	313.50	16.08	160.77
30	$353.31	317.98	16.31	163.07
31	$360.78	324.70	16.65	166.51
32	$368.25	331.43	17.00	169.96
33	$372.92	335.63	17.21	172.12
34	$377.90	340.11	17.44	174.42
35	$380.39	342.35	17.56	175.56
36	$382.88	344.59	17.67	176.71
37	$385.37	346.83	17.79	177.86
38	$387.87	349.08	17.90	179.02
39	$392.85	353.57	18.13	181.32
40	$397.83	358.05	18.36	183.61
41	$405.30	364.77	18.71	187.06
42	$412.46	371.21	19.04	190.37
43	$422.42	380.18	19.50	194.96
44	$434.87	391.38	20.07	200.71
45	$449.50	404.55	20.75	207.46
46	$466.93	420.24	21.55	215.51
47	$486.54	437.89	22.46	224.56
48	$508.96	458.06	23.49	234.90
49	$531.06	477.95	24.51	245.10
50	$555.96	500.36	25.66	256.60
51	$580.55	522.50	26.79	267.95
52	$607.63	546.87	28.04	280.44
53	$635.03	571.53	29.31	293.09
54	$664.60	598.14	30.67	306.74
55	$694.17	624.75	32.04	320.39
56	$726.24	653.62	33.52	335.19
57	$758.61	682.75	35.01	350.13
58	$793.16	713.84	36.61	366.07
59	$810.28	729.25	37.40	373.98
60	$844.84	760.36	38.99	389.93
61	$874.72	787.25	40.37	403.72
62	$894.33	804.90	41.28	412.77
63	$918.92	827.03	42.41	424.12
64 & over	$933.86	840.47	43.10	431.01

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