

# Family Medicine of Mt Pleasant PC

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

	In-Network Only
<b>Plan Name/ Network</b>	CompleteBlue 4000 HMO
<b>Office Visit including Chiropractic</b>	\$40 PCP / <b>\$90 Specialist Copay</b> Virtual Visit: \$40 Copay
<b>Deductible</b>	\$4,000 Single / \$8,000 Family
<b>Coinsurance</b>	70% / 30%
<b>Out-of-Pocket</b>	<b>\$8,150 Single / \$16,300 Family</b>
<b>Lifetime Maximum</b>	Unlimited
<b>Adult Routine Exam</b>	Covered - 100%
<b>Mental Health/Substance Abuse</b>	Covered as any other illness.
<b>Emergency Room Visits</b>	\$500 Copay
<b>Inpatient Hospital</b>	Deductible + 30%
<b>Outpatient Hospital</b>	Deductible + 30%
<b>Rx Benefits</b>	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
<b>Annual Vision Exam</b>	Child only: Exam: 100% / Glasses: \$130 Allowance
<b>Rate Guarantee</b>	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 <i>(from age rate chart)</i>
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.

# Family Medicine of Mt Pleasant PC

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

**Employee Name:** \_\_\_\_\_

Dental Benefits: Delta Dental of Iowa	
<b>Network Name</b>	Delta Dental Premier - Plan B Prime w/ Ortho
<b>Network Availability</b>	10 general dentists within 15 miles
<b>Calendar Year Benefit</b>	\$2,000
<b>Deductible</b>	\$25 per enrollee waived for D&P
<b>Coinsurance</b>	
<b>Preventive</b>	100% / 0%
<b>Basic</b>	80% / 20%
<b>Major</b>	50% / 50%
<b>Vision Discount Card</b>	Included
<b>Ortho Lifetime Benefit</b>	*\$1,500
<b>Orthodontia</b>	* 50% / 50%
<b>Annual Rollover</b>	Included
Adult	\$42.90 per person per month
Child (up to age 20)	\$33.56 per person per month

*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	
<b>Network Name</b>	VSP Choice
<b>Network Availability</b>	7 clinics within 25 miles
<b>Examinations / Frequency</b>	\$10 copay / 1 exam every 12 months
<b>Lenses / Frequency</b>	
<i>Single vision, Lined bifocal, Lined trifocal, Lenticular</i>	Covered in full after \$30 copay / every 12 months
<b>Frames / Frequency</b>	\$130 retail allowance after \$30 copay / every 12 months
<b>Contact Lenses / Frequency</b>	\$130 retail allowance after \$30 copay / every 12 months (in place of lenses & frames)
Employee	\$10.74 per month
Employee + Spouse	\$17.18 per month
Employee + Child(ren)	\$17.54 per month
Employee + Family	\$28.27 per month

*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.

Age	Full Monthly Premium	Employee		Spouse/Dependent
		Clinic Pays Per Month	Employee Pays Per Pay Period	Employee Pays Per Pay Period2
0-14	\$238.14	214.33	23.81	238.14
15	\$259.30	233.37	25.93	259.30
16	\$267.40	240.66	26.74	267.40
17	\$275.49	247.94	27.55	275.49
18	\$284.21	255.79	28.42	284.21
19	\$292.92	263.63	29.29	292.92
20	\$301.95	271.76	30.20	301.95
21	\$311.29	280.16	31.13	311.29
22	\$311.29	280.16	31.13	311.29
23	\$311.29	280.16	31.13	311.29
24	\$311.29	280.16	31.13	311.29
25	\$312.53	281.28	31.25	312.53
26	\$318.76	286.88	31.88	318.76
27	\$326.23	293.61	32.62	326.23
28	\$338.37	304.53	33.84	338.37
29	\$348.33	313.50	34.83	348.33
30	\$353.31	317.98	35.33	353.31
31	\$360.78	324.70	36.08	360.78
32	\$368.25	331.43	36.83	368.25
33	\$372.92	335.63	37.29	372.92
34	\$377.90	340.11	37.79	377.90
35	\$380.39	342.35	38.04	380.39
36	\$382.88	344.59	38.29	382.88
37	\$385.37	346.83	38.54	385.37
38	\$387.87	349.08	38.79	387.87
39	\$392.85	353.57	39.29	392.85
40	\$397.83	358.05	39.78	397.83
41	\$405.30	364.77	40.53	405.30
42	\$412.46	371.21	41.25	412.46
43	\$422.42	380.18	42.24	422.42
44	\$434.87	391.38	43.49	434.87
45	\$449.50	404.55	44.95	449.50
46	\$466.93	420.24	46.69	466.93
47	\$486.54	437.89	48.65	486.54
48	\$508.96	458.06	50.90	508.96
49	\$531.06	477.95	53.11	531.06
50	\$555.96	500.36	55.60	555.96
51	\$580.55	522.50	58.05	580.55
52	\$607.63	546.87	60.76	607.63
53	\$635.03	571.53	63.50	635.03
54	\$664.60	598.14	66.46	664.60
55	\$694.17	624.75	69.42	694.17
56	\$726.24	653.62	72.62	726.24
57	\$758.61	682.75	75.86	758.61
58	\$793.16	713.84	79.32	793.16
59	\$810.28	729.25	81.03	810.28
60	\$844.84	760.36	84.48	844.84
61	\$874.72	787.25	87.47	874.72
62	\$894.33	804.90	89.43	894.33
63	\$918.92	827.03	91.89	918.92
64 & over	\$933.86	840.47	93.39	933.86

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