RUAN 2027 Health Plans

Medical Plan Options

All plans administered by Wellmark Blue Cross Blue Shield. Georgia residents utilize the Blue Open Access POS Network, Iowa residents the Wellmark Blue POS Network, Wisconsin residents the Blue Preferred POS Network, and all other states the Wellmark Blue PPO Network.

	LIGHT	BASIC	CHOICE	PREMIER
Preventative Care	100% in-network	100% in-network	100% in-network	100% in-network
Doctor on Demand (virtual visit)	$0 routine visit $0 mental health	20% after deductible routine visit 20% after deductible mental health	$0 after deductible/OPM routine visit $0 after deductible/OPM mental health	$0 routine visit $0 mental health
Primary Care Office Visit	$25 co-pay	$30 after deductible	$0 after deductible	$25 co-pay
Urgent Care or Specialist Office Visits	$50 co-pay	$30 after deductible	$0 after deductible	$25 co-pay
Deductible	$5,000 Single / $10,000 Family	$3,500 Single / $7,000 Family	$2,750 Single / $5,500 Family	$500 Single (medical only) / $1,000 Family (medical only)
Co-Insurance	50% after deductible	20% after deductible	0% after deductible	10%
Out-of-Pocket Maximum (OPM)	$6,850 Single / $13,700 Family	$5,250 Single / $10,500 Family	$2,750 Single / $5,500 Family	$2,000 Single (medical only) / $4,000 Family (medical only)

1) Use of non-network providers will reduce your benefit(s) and increase your deductible and/or out-of-pocket maximum.
2) Both the Basic and Choice plans are high deductible plans; you pay 100% of claims, except preventive and well-baby care, until the deductible is met.
3) Preventive Care guidelines state a preventive exam/procedure that becomes diagnostic must apply to the deductible.
4) A working spouse who has other coverage available through their own employer will not be eligible to enroll in a Ruan medical plan. Refer to Working Spouse Exclusion in the Employee Benefits Guide.
5) Under Choice plans, +Spouse, +Child(ren), or Family elections share the higher family deductible and out-of-pocket maximums.
6) Virtual visits outside of the Doctor on Demand platform will apply to the plan's deductible or copay.

Prescription Drug

All medical plans include prescription drug coverage administered by CVS Caremark.

	LIGHT	BASIC		CHOICE		PREMIER
		PREVENTIVE	ALL OTHERS	PREVENTIVE	ALL OTHERS	
Tier 1- Generic	$15	$20 or 25% *(whichever is greater)*	$20 or 25% *(whichever is greater after deductible)*	$0	$0 *(after deductible)*	$10 or 25% *(whichever is greater)*
Tier 2- Select Brands	50% *(after deductible)*	$35 or 25% *(whichever is greater)*	$35 or 25% *(whichever is greater after deductible)*	$0	$0 *(after deductible)*	25%
Tier 3- All Other Brands	50% *(after deductible)*	$50 or 25% *(whichever is greater)*	$50 or 25% *(whichever is greater after deductible)*	$0	$0 *(after deductible)*	25%
Specialty Drugs	50% *(after deductible)*	Generic/Select Brands: $35 or 25% *(whichever is greater; after deductible)* Non-Select Brands: $50 or 25% *(whichever is greater; after deductible)*		$0 *(after deductible/OPM)*		10% co-insurance

1) Out-of-Network benefits equal your co-pay or 50%, whichever is greater, and is subject to Usual Customary & Reasonable charges (UCR).
2) Under the Basic and Choice plans, the deductible is waived for preventive medication. To see if a medication is on the Wellmark HSA Drug List please visit wellmark.com.
3) Under the Premier plan your Rx cost share does not apply to the plan's deductible or out-of-pocket maximum (OPM). A separate Rx OPM of $2,000 single/$4,000 family applies.
4) There is a mail order program available for high cost maintenance drugs. For three co-pays you receive a 90 day supply without the "whichever is greater" clause, allowing additional savings.
5) All specialty drugs must be filled through the CVS Specialty Pharmacy to be covered by insurance.

Dental

Plans administered by Delta Dental of Iowa and offer Delta Premier or Delta PPO networks.

	STANDARD DENTAL		PREMIER DENTAL	
	PREMIER NETWORK	PPO NETWORK	PREMIER NETWORK	PPO NETWORK
Preventative Care	0% co-insurance		0% co-insurance	
Annual Deductible	$50	$25	$25	$15
Basic Care	20% *(after deductible)*	10% *(after deductible)*	20% *(after deductible)*	10% *(after deductible)*
Major Care	50% *(after deductible)*		50% *(after deductible)*	
Dental Maximum	$1,000/year/person		$2,000/year/person	
Orthodontia *(children age 19 and younger only)*	$50 ortho. deductible, then 50% Lifetime max: $1,000		$50 ortho. deductible, then 50% Lifetime max: $1,500	

1) *Out-of-Network rates are subject to Usual Customary & Reasonable charges.

Vision

Plans administered by VSP and utilize the VSP Advantage network.

	IN-NETWORK
Annual Exam *(once per 12 months)*	$10 co-pay
Lenses *(once per 12 months)*	$25 co-pay
Frames *(once per 24 months)*	$175 allowance
Contacts – in lieu of glasses Contact Lens Fitting	$175 allowance up to $60 allowance

1) Network providers offer discounts up to a 20% on goods and services.
2) Members are responsible for charges over the annual plan allowances.

Note: This handout is for informational purposes only. If there are any discrepancies between this brochure and the plan document, the plan document will govern. For more information, please consult the Employee Benefits Guide, Summary Plan Description, or Employee Policy Manual.

Additional details are available at ***Ruan.com/Benefits*** or on the Ruan Hub.

HUMAN RESOURCES HOTLINE | **1-800-845-6675** | 8:30 AM-4:30PM CST | ***BENEFITS@RUAN.COM***