Questions: Benefits Office 633-5076

	Wellmark Plan of Iowa (WHPI) Blue Access - Plan 1		BLUE PPO - Plan 2		BLUE PPO - Plan 3		BLUE PPO - Plan 4	
BENEFIT OVERVIEW	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible - Calendar Year								
Single	$600	No coverage	$1,000	$2,000	$1,500	$3,000	$2,000	$4,000
Family	$1,200	No coverage	$2,000	$4,000	$3,000	$6,000	$4,000	$8,000
Coinsurance	10%	No coverage	20%	30%	20%	30%	20%	30%
Out-of-Pocket Maximum - Calendar Year								
Single Medical/ Prescription Drugs (each are separate)	$1750/$1750	N/A	$2750/$2750	$5500/$5500	$3750/$3750	$7500/$7500	$4000/$4000	$8000/$8000
Family Medical/Prescription Drugs (each are separate)	$3500/$3500	N/A	$5500/$5500	$11000/$11000	$7500/$7500	$15000/$15000	$8000/$8000	$16000/$16000
Lifetime Maximum	Unlimited		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
BENEFIT HIGHLIGHTS	**BENEFIT HIGHLIGHTS**		**BENEFIT HIGHLIGHTS**		**BENEFIT HIGHLIGHTS**		**BENEFIT HIGHLIGHTS**	
Physician Visit-Office Visits	**In-Network**	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**	**In Network**	**Out-of-Network**
Routine: Physicals, Gynecological Exam, Pap smears, and mammograms	$25 Copay Waived, 100% paid by Wellmark	Not Covered	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay
Non-Routine: Physicals, Gynecological Exam, Pap smears, and mammograms	$25 Copay	Not Covered	$25 Copay	$50 Copay	$25 Copay	$50 Copay	$25 Copay	$50 Copay
Routine Eye Exam (Includes Refraction)*	$25 Copay Waived, 100% paid by Wellmark	Not Covered	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay
Well Child Care & Immunizations	$25 Copay Waived, 100% paid by Wellmark	Not Covered	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay	$25 Copay Waived, 100% paid by Wellmark	$50 Copay
Primary Care Office Vist Other than routine noted above	$25 Copay	Not Covered	$25 Copay	$50 Copay	$25 Copay	$50 Copay	$25 Copay	$50 Copay
Specialist	$50 Copay	Not Covered	$50 Copay	$75 Copay	$50 Copay	$75 Copay	**$75 Copay**	**$100 Copay**
IOWA CLINIC High Performance Network (Voluntary)	$0 Copay	N/A	$0 Copay	N/A	$0 Copay	N/A	$0 Copay	N/A
Doctor - On - Demand	$0 Copay	N/A	$0 Copay	N/A	$0 Copay	N/A	$0 Copay	N/A
Maternity Services								
Prenatal & Postnatal Physician Services	$25 Copay	Not Covered	$25 Copay	$50 Copay	$25 Copay	$50 Copay	$25 Copay	$50 Copay
Delivery & Surgery Charges (If doctor includes prenatal care with delivery charges, they will be screened with delivery charges)	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Inpatient Hospital Care	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Outpatient X-Ray & Laboratory	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Hospital Services								
Inpatient	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Unlimited Hospital Days (Semi-Private), Private Room-Medically Necessary, Medications/Drugs, Nursing Care, Professional Services, X-Ray & Lab, Intensive / Coronary Care, Radiation Therapy, Administration of Blood	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Outpatient								
X-Rays & Laboratory, Ambulatory Surgery	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
X-Ray & Laboratories that are related to Routine Physicals (Mammograms, Colonoscopies, etc.)	Deductible waived, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance

2022-23 Medical and Prescription Drug Benefit Comparison

West Des Moines Community Schools

Effective July 1, 2022

BENEFIT OVERVIEW -	PLAN 1 (WHPI) BENEFIT HIGHLIGHTS:		PLAN 2 (PPO) BENEFIT HIGHLIGHTS:		PLAN 3 (PPO) BENEFIT HIGHLIGHTS:		PLAN 4 (PPO) BENEFIT HIGHLIGHTS:	
Short-Term Therapies	**In-Network**	**Out Of Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Speech, Occupational, Respiratory, Cardiac Rehabilitation (Short-term therapies are covered as medically necessary)	Deductible, 10% Coinsurance If in the office: $50 Copay	Not Covered	Deductible, 20% Coinsurance If in the office: $50 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance If in the office: $50 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance If in the office: $50 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay
Voluntary Family Planning								
Elective Sterilization, Male or Female	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance If in the office: $50 Copay
Infertility Services **$25,000 Lifetime maximum. Coinsurance does not count towards out-of-pocket maximum.**	Deductible, 10% Coinsurance If in the office $25 Copay	Not Covered	Deductible, 20% Coinsurance If in the office: $25 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance If in the office: $25 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay	Deductible, 20% Coinsurance If in the office: $25 Copay	Deductible, 30% Coinsurance If in the office: $50 Copay
Nursing Facility								
Facility, supplies & equipment authorized in lieu of acute care hospitalization in the service area.	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Home Health Care								
Authorized in lieu of acute care hospitalization within the service area	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Hospice	Deductible Waived, 10% Coinsurance	Not Covered	Deductible Waived, 20% Coinsurance	Deductible waived, 30% Coinsurance	Deductible Waived, 20% Coinsurance	Deductible waived, 30% Coinsurance	Deductible Waived, 20% Coinsurance	Deductible waived, 30% Coinsurance
Prosthetic Devices & Durable Medical Equipment								
Authorized certain prosthetic devices & durable medical equipment	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Emergency Care Services								
Physician Office	$25 Copay	Not Covered	$25 Copay	$50 Copay	$25 Copay	$50 Copay	$25 Copay	$50 Copay
Emergency Room	$250 Copay, then Deductible and Coinsurance	Only coverage in Emergency	$250 Copay, then Deductible and Coinsurance	$250 Copay followed by Deductible and Coinsurance	$250 Copay, then Deductible and Coinsurance	$250 Copay followed by Deductible and Coinsurance	$250 Copay, then Deductible and Coinsurance	$250 Copay followed by Deductible and Coinsurance
Ambulance	$75 Copay	Only coverage in Emergency	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay	$75 Copay
Prescription Drugs with MedOne/CanaRX *MedOne is also the mail order prescription provider* *Cana RX is a voluntary mail order program for certain prescription drugs*	$5-Tier 1 /$20 - Tier 2/ $45 - Tier 3/No coverage Non-Formulary/$100 Specialty Preferred/50% Specialty Non-referred Single Calendar Year Deductible: $50 Family Calendar Year Deductible: $100 **Deductible does not apply to Tier 1** CanaRx - $0						**$10-Tier 1 /$40 - Tier 2/ $90 - Tier 3/No coverage Non-Formulary/$100 Specialty Preferred/50% Specialty Non-referred Single Calendar Year Deductible: $50 Family Calendar Year Deductible: $100 Deductible does not apply to Tier 1 CanaRx - $0**	
Mental Health/Chemical Dependency								
Inpatient	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Outpatient	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
Office	**$25 Copay**	Not Covered	**$25 Copay**	$50 Copay PCP $75 Copay Non PCP	**$25 Copay**	$50 Copay PCP $75 Copay Non PCP	**$25 Copay**	**$75 Copay PCP $100 Copay Non PCP**

The plan includes coverage for refractions with vision exams, effective July 1, 2015.

If services are billed as an office visit, then copays apply.

Copays count towards the out-of-pocket maximum (OPM). There are separate OPM for Medical and Prescription Drugs

If services are billed as outpatient or inpatient, then deductibles and Coinsurance apply.

Note: This is a summary of benefits provided by the plans. It is not a statement of contract. Refer to the carrier's descriptive material for a full discussion of benefits. Actual coverage is subject to terms and conditions specified in the Benefits Certificate and the enrollment regulations in force when the certificate becomes effective. Please call our benefits office at 633-5076 if you would like a copy. Certain exclusions