

West Des Moines Community Schools
2021-2022 Medical and Prescription Drug Benefit Comparison
Effective July 1, 2021

Questions:
Benefits Office 633-5076

Wellmark BCBS of Iowa

	Wellmark Plan of Iowa (WHPI) Blue Access - Plan 1		BLUE PPO - Plan 2		BLUE PPO - Plan 3	
BENEFIT OVERVIEW	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<u>Deductible - Calendar Year</u>						
Single	\$600	No coverage	\$1,000	\$2,000	\$1,500	\$3,000
Family	\$1,200	No coverage	\$2,000	\$4,000	\$3,000	\$6,000
<u>Coinsurance</u>	10%	No coverage	20%	30%	20%	30%
<u>Out-of-Pocket Maximum - Calendar Year</u>						
Single Medical/ Prescription Drugs (each are separate)	\$1750/\$1750	N/A	\$2750/\$2750	\$5500/\$5500	\$3750/\$3750	\$7500/\$7500
Family Medical/Prescription Drugs (each are separate)	\$3500/\$3500	N/A	\$5500/\$5500	\$11000/\$11000	\$7500/\$7500	\$15000/\$15000
<u>Lifetime Maximum</u>	Unlimited		Unlimited	Unlimited	Unlimited	Unlimited
BENEFIT HIGHLIGHTS	BENEFIT HIGHLIGHTS		BENEFIT HIGHLIGHTS		BENEFIT HIGHLIGHTS	
<u>Physician Visit-Office Visits</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In Network</u>	<u>Out-of-Network</u>	<u>In Network</u>	<u>Out-of-Network</u>
<u>Routine:</u> 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
<u>Non-Routine:</u> Physicals, Gynecological Exam, Pap smears, and mammograms	\$25 Copay	Not Covered	\$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
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
Primary Care Office Visit Other than routine noted above	\$25 Copay	Not Covered	\$25 Copay	\$50 Copay	\$25 Copay	\$50 Copay
Specialist	\$50 Copay	Not Covered	\$50 Copay	\$75 Copay	\$50 Copay	\$75 Copay
<u>Doctor - On - Demand</u>	\$0 Copay	N/A	\$0 Copay	N/A	\$0 Copay	N/A
<u>Maternity Services</u>						
Prenatal & Postnatal Physician Services	\$25 Copay	Not Covered	\$25 Copay	\$50 Copay	\$25 Copay	\$50 Copay
<u>Delivery & Surgery Charges</u> (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
Inpatient Hospital Care	Deductible, 10% Coinsurance	Not Covered	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
<u>Hospital Services</u>						
Inpatient	Deductible, 10% Coinsurance	Not Covered	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
Outpatient						
X-Rays & Laboratory, Ambulatory Surgery	Deductible, 10% Coinsurance	Not Covered	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

BENEFIT OVERVIEW -	PLAN 1 (WHPI) BENEFIT HIGHLIGHTS:		PLAN 2 (PPO) BENEFIT HIGHLIGHTS:		PLAN 3 (PPO) BENEFIT HIGHLIGHTS:	
<p><u>Short-Term Therapies</u> Physical, Speech, Occupational, Respiratory, Cardiac Rehabilitation (Short-term therapies are covered as medically necessary)</p> <p><u>Voluntary Family Planning</u> Elective Sterilization, Male or Female</p> <p><u>Infertility Services</u> \$25,000 Lifetime maximum. Coinsurance does not count towards out-of-pocket maximum.</p> <p><u>Nursing Facility</u> Facility, supplies & equipment authorized in lieu of acute care hospitalization in the service area.</p> <p><u>Home Health Care</u> Authorized in lieu of acute care hospitalization within the service area</p> <p><u>Hospice</u></p> <p><u>Prosthetic Devices & Durable Medical Equipment</u> Authorized certain prosthetic devices & durable medical equipment</p> <p><u>Emergency Care Services</u> Physician Office Emergency Room Ambulance</p>	<u>In-Network</u>	<u>Out Of Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
	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, 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
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	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
	Deductible Waived, 10% Coinsurance	Not Covered	Deductible Waived, 20% Coinsurance	Deductible waived, 30% Coinsurance	Deductible Waived, 20% Coinsurance	Deductible waived, 30% Coinsurance
	Deductible, 10% Coinsurance	Not Covered	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance	Deductible, 20% Coinsurance	Deductible, 30% Coinsurance
	\$25 Copay \$250 Copay, then Deductible and Coinsurance	Not Covered Only coverage in Emergency	\$25 Copay \$250 Copay, then Deductible and Coinsurance	\$50 Copay \$250 Copay followed by Deductible and Coinsurance	\$25 Copay \$250 Copay, then Deductible and	\$50 Copay \$250 Copay followed by Deductible and Coinsurance
	\$75 Copay	Only coverage in Emergency	\$75 Copay	\$75 Copay	\$75 Copay	\$75 Copay
<u>Prescription Drugs</u>	\$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					
<u>Mental Health/Chemical Dependency</u>						
Inpatient	Deductible, 10% Coinsurance	Not Covered	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
Office	\$25 Copay	Not Covered	\$25 Copay	\$50 Copay PCP \$75 Copay Non PCP	\$25 Copay	\$50 Copay PCP \$75 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 and limitations apply.