West Des Moines Community Schools

2019-2020 Medical and Prescription Drug Benefit Comparison - PPO

Effective July 1, 2019

Questions:
Benefits Office 633-5076

Wellmark BCBS of Iowa --ALLIANCE SELECT PPO

	Alliance Select - Plan 1		Alliance Select - Plan 2		Alliance Select - Plan 3	
BENEFIT OVERVIEW - PPO	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible - Calendar Year						
Single	$300	$300	$600	$600	$1,000	$1,000
Family	$600	$600	$1,200	$1,200	$2,000	$2,000
Coinsurance	10%	20%	10%	20%	10%	20%
Out-of-Pocket Maximum - Calendar Year						
Single Medical/ Prescription Drugs (each are separate	$750/$750	$750/$750	$1500/$1500	$1500/$1500	$2500/$2500	$2500/$2500
Family Medical/Prescription Drugs (each are separate)	$1500/$1500	$1500/$1500	$3000/$3000	$3000/$3000	$5000/$5000	$5000/$5000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
BENEFIT HIGHLIGHTS	**BENEFIT HIGHLIGHTS FOR PLANS 1, 2, 3**					
Physician Visit-Office Visits	**In-Network**				**Out-of-Network**	
Routine: Physicals, Gynecological Exam, Pap smears, and mammograms	$15 Copay Waived, 100% paid by Wellmark				$25 Copay	
Non-Routine: Physicals, Gynecological Exam, Pap smears, and mammograms	$15 Copay				$25 Copay	
Routine Eye Exam (Includes Refraction)*	$15 Copay Waived, 100% paid by Wellmark				$25 Copay	
Well Child Care & Immunizations	$15 Copay Waived, 100% paid by Wellmark				$25 Copay	
Office Vist Other than routine noted above	$15 Copay				$25 Copay	
Chiropractic Care	$15 Copay				$25 Copay	
Doctor - On - Demand	$5 Copay				$5 Copay	
Maternity Services						
Prenatal & Postnatal Physician Services	$15 Copay				$25 Copay	
Delivery & Surgery Charges (If doctor includes prenatal care with delivery charges, they will be screened with delivery charges)	Deductible, 10% Coinsurance				Deductible, 20% Coinsurance	
Inpatient Hospital Care	Deductible, 10% Coinsurance				Deductible, 20% Coinsurance	
Outpatient X-Ray & Laboratory	Deductible, 10% Coinsurance				Deductible, 20% Coinsurance	
Hospital Services						
Inpatient	Deductible, 10% Coinsurance				Deductible, 20% 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						
Outpatient X-Rays & Laboratory, Ambulatory Surgery	Deductible, 10% Coinsurance				Deductible, 20% Coinsurance	
X-Ray & Laboratories that are related to Routine Physicals (Mammograms, Colonoscopies, etc.)	Deductible waived, 10% Coinsurance				Deductible, 20% Coinsurance	

Wellmark BCBS of Iowa - PPO

BENEFIT OVERVIEW - PPO	BENEFIT HIGHLIGHTS FOR PLANS 1, 2, 3		
Short-Term Therapies	**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: $15 Copay		Deductible, 20% Coinsurance If in the office: $25 Copay
Voluntary Family Planning			
Elective Sterilization, Male or Female	Deductible, 10% Coinsurance If in the office: $15 Copay		Deductible, 20% Coinsurance If in the office: $25 Copay
Infertility Services **$25,000 Lifetime maximum. Coinsurance does not count towards out-of-pocket maximum.**	Deductible, 10% Coinsurance If in the office: $15 Copay		Deductible, 20% Coinsurance If in the office: $25 Copay
Nursing Facility			
Facility, supplies & equipment authorized in lieu of acute care hospitalization in the service area.	Deductible, 10% Coinsurance		Deductible, 20% Coinsurance
Home Health Care			
Authorized in lieu of acute care hospitalization within the service area	Deductible, 10% Coinsurance		Deductible, 20% Coinsurance
Hospice	Deductible waived, 10% Coinsurance		Deductible waived, 20% Coinsurance
Prosthetic Devices & Durable Medical Equipment			
Authorized certain prosthetic devices & durable medical equipment	Deductible, 10% Coinsurance		Deductible, 20% Coinsurance
Emergency Care Services			
Physician Office Emergency Room Ambulance	$15 Copay $75 Copay $75 Copay		$25 Copay $75 Copay $75 Copay
Prescription Drugs	$5 Generic/$20 Brand Name Formulary/$45 Brand Name Non-Formulary Single Calendar Year Deductible: $50 Family Calendar Year Deductible: $100 **Deductible does not apply to Generic Drugs**		
Mental Health/Chemical Dependency			
Inpatient	Deductible, 10% Coinsurance		Deductible, 20% Coinsurance
Outpatient	Deductible, 10% Coinsurance		Deductible, 20% Coinsurance
Office	$15 Copay		$25 Copay
Total Monthly Premium Rates:	**Plan 1**	**Plan 2**	**Plan 3**
Employee	$559.14	$536.78	$503.22
Employee/Spouse	$1,230.12	$1,180.92	$1,107.10
Employee/Child(ren)	$1,062.38	$1,019.88	$956.14
Family	$1,677.42	$1,610.34	$1,509.68

*** 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 deductible or 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.